BLOODBORNE PATHOGENS
EXPOSURE CONTROL PLAN

Approvals:

_____	_____	_____
Fire/Rescue Chief	***City Manager***	***Director Human Resources***
_____	_____	_____
Capt. Chuck Owens	***Capt. Leonard Waters***	***Capt. Leonard Sawyer***
_____	_____	
Capt. Walter Salisbury	***Safety / Risk Manager***	

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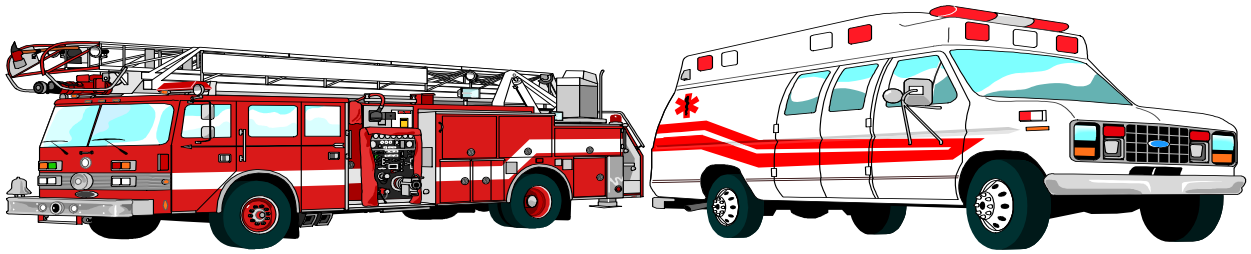

Greenville Fire/Rescue Department
City of Greenville, NC

Revisions Page

Original Infection Control Plan developed in 1985

Next update of Infection Control Plan came into effect in 1992, compliant with 29 CFR 1910.1030.

2003

Revision 0	9/29/03	_____
Revision 1	10/13/03	_____
Revision 2	11/26/03	_____

2004

Revision 3	03/18/04	_____
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Article I Purpose

Section 1.1 Blood and other body fluids have long been recognized as potential sources of pathogenic microorganisms that may present a risk to individuals who are exposed during the performance of their duties. This plan is designed to eliminate or minimize employee exposure to blood and/or certain other body fluids.

Section 1.2 This plan is set forth to comply with OSHA Bloodborne Pathogens Standard, 29 CFR 1910.1030.

Article II Plan Statement

Section 2.1 The Greenville Fire/Rescue Department recognizes the potential exposure of its employees to communicable diseases in the performance of their duties and in the normal work environment. To minimize the risk of exposure, the Greenville Fire/Rescue Department will implement an Exposure Control Plan.

The Exposure Control Plan will include standard operating procedures, initial training and continuing education in exposure control practices, a vaccination program, the provision of proper exposure control clothing and equipment, decontamination procedures for clothing and equipment, procedures for the disposal of medical waste, a system for reporting and managing exposures, a system for tracking exposures and ensuring confidentiality, and the monitoring of compliance with the standard operating procedures.

In the emergency care setting, the communicable disease status of patients is frequently unknown by Greenville Fire/Rescue Department personnel. All patients must be considered infectious. The Greenville Fire/Rescue Department will follow “Body Substance Isolation" procedures, to reduce to a minimum the potential for exposure to blood and other body fluids.

Finally, an exposure incident shall be considered an occupational health hazard.

Article III Scope

Section 3.1 This plan applies to all occupational exposures to blood and other potentially infectious materials. Compliance to this plan is a requirement of all Fire/Rescue personnel.

Article IV Roles and Responsibilities

Section 4.1 ***Chief*** - The tasks of managing the department Occupational Health & Safety and Exposure Control Plan is delegated to appropriate staff officers and committees as noted below. The ultimate responsibility for the health and welfare of all employees remains that of the Chief of the Department.

Section 4.2 ***Department Designated Officer (DO)*** - The EMS Manager shall serve in this role. The Department Designated Officer (EMS Manager) and the three Shift Designated Officers’ will:

a. Serve as the department "designated officer" as required by the Ryan White Comprehensive AIDS Resources Act of 1990 (PL101-381).

b. In conjunction with the Exposure Control Committee and input from direct care employees, develop criteria for the purchase of exposure control personal protective equipment and devices and determine adequate stocking levels for each station and response vehicle.

c. Evaluate possible employee exposures to communicable diseases and coordinate communications between the department, the hospital, the City physician, and the County Health Department.

d. Conduct spot inspections of on-scene and station operations to ensure compliance with the department exposure control policy.

e. Coordinate the immunization program and maintain program immunization records.

f. Maintain a confidential database of exposures and treatment provided.

g. Develop and deliver a comprehensive exposure control educational plan which complies with OSHA Regulation 29 CFR Part 1910.1030.

h. Interview and counsel exposed employees and others as deemed appropriate.

i. Monitor the development and revision of the Exposure Control Plan.

j. Keep abreast of new developments in the field of exposure control and make appropriate recommendations to the Exposure Control Committee.

k. Be available at all times (24/7) for consultation in any matter pertaining to this plan.

Section 4.3 ***Chief and company officers*** - These officers will be responsible for:

a. Supporting and enforcing compliance with the Exposure Control Plan.

b. Conducting spot inspections of on-scene and station operations to ensure compliance with the department exposure control policy.

c. Correcting any and all unsafe acts, and referring employees for remedial exposure control training if required.

d. Mandating safe operating practices on-scene and in-station.

e. Referring for medical evaluation any employee possibly unfit for work due to potential of or for infection.

Section 4.4 ***All Employees*** will:

a. Assume ultimate responsibility for their health and safety.

b. Always use appropriate PPE as the situation dictates.

c. Report any suspected occupational exposure to communicable disease to their company officer.

d. Participate in mandatory training as required by this plan.

e. Seek medical evaluation as required by this plan.

Section 4.5 ***City Attorney*** - The City Attorney will review the Exposure Control Plan and each subsequent revision. The City Attorney will inform the Exposure Control Committee of any regulations (local, state, or federal) that may impact the Exposure Control Plan.

Section 4.6 ***Exposure Control Committee*** - This committee will be responsible for conducting periodic review and revision of the Department Exposure Control Plan, review of compliance monitoring, and discussion of exposure incidents.

This Committee will consist of:

EMS Manager - Chair
Shift One Officer
Shift Two Officer
Shift Three Officer
Safety / Risk Manager

Article V Definitions **(definitions taken from OHSA 1910.1030(b), Center of Disease Control, CDC, and references listed on page 61 of this plan)**

Section 5.1 ***AIDS:*** Acquired Immune Deficiency Syndrome, a communicable disease caused by Human Immunodeficiency Virus (HIV).

Section 5.2 ***Airborne Pathogen****:* Pathologic microorganisms spread by droplets expelled into the air, typically through a productive cough or sneeze.

Section 5.3 ***Antibody****:* A component of the immune system that eliminates or counteracts a foreign substance (antigen) in the body.

Section 5.4 ***Antigen:*** A foreign substance that stimulates the production of antibodies in the immune system.

Section 5.5 ***ARC:*** (AIDS Related Complex) An outdated term used to describe symptoms of HIV infection in patients who have not developed AIDS. These include fatigue, diarrhea, night sweats, and enlarged lymph nodes. ARC is not included in the current Centers for Disease Control classification of HIV infection.

Section 5.6 ***Bacteria****:* A type of living microorganism that can produce disease in a suitable host. Bacteria can self-reproduce, and some forms may produce toxins harmful to their host.

Section 5.7 ***Basic Life Support (BLS)****:* Emergency medical treatment at a level authorized to be performed by emergency medical technicians as defined by the medical authority having jurisdiction.

Section 5.8 ***Blood***: Means human blood, human blood components, and products made from human blood. (OSHA)

Section 5.9 ***Bloodborne Pathogen****:* Pathologic microorganisms that are present in human blood

and that can cause disease in humans. (OSHA) NOTE: the term "blood" includes blood, blood components, and products made from human blood. These pathogens include, but are not limited to, hepatitis B virus (HBV) and human immunodeficiency virus. (HIV). (OSHA)

Section 5.10 ***Blood Exposure Report**:* This is the report form found in the Prehospital Personnel Communicable Disease Exposure Policy, to be completed and forwarded to the Epidemiology Department of PCMH following an exposure. (Attachment 3)

Section 5.11 ***Body Fluids**:* Fluids that have been recognized by the CDC that have been directly linked to the transmission of HIV and/or HBV and/or to which Universal Precautions or Body Substance Isolation apply: blood, semen, blood products, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid, amniotic fluid, and concentrated HIV or HBV viruses.

Section 5.12 ***Body Substance Isolation**:* This term refers to a system of disease control which identifies all body fluids and substances as potentially infectious, unlike Universal Precautions which only addresses "blood and certain body fluids."

Section 5.13 ***CDC***: Centers for Disease Control.

Section 5.14 ***Cleaning:*** The physical removal of dirt and debris.

Section 5.15 ***Communicable Disease**:* A disease that can be transmitted from one person to another. Also known as a contagious disease.

Section 5.16 ***Contaminated**:* The presence or the reasonably anticipated presence of blood or other potentially infectious materials on an item or surface that poses a threat to life, health, or the environment. (OSHA)

Section 5.17 ***Contaminated Laundry**:* This term identifies laundry that has been soiled with blood or other potentially infectious materials or may contain sharps.

Section 5.18 ***Contaminated Sharps**:* Means any contaminated object that can penetrate the skin including, but not limited to, needles, scalpels, broken glass, broken capillary tubes, and exposed ends of dental wires. (OSHA)

Section 5.19 ***Decontamination**:* Means the use of physical or chemical means to remove, inactivate, or destroy bloodborne pathogens on a surface or item to the point where they are no longer capable of transmitting infectious particles and the surface or item is rendered safe for handling, use, or disposal. (OSHA)

Section 5.20 ***Designated Officer**:* A member of a department assigned specific responsibility for department exposure control practices, including immunizations and post exposure follow-up protocols. This officer fulfills the responsibilities for designated officer listed in the Ryan White Comprehensive AIDS Resources Emergency Act of 1990.

Section 5.21 ***Disinfection**:* A procedure that inactivates virtually all recognized pathogenic microorganisms, but not necessarily all microbial forms *(ex.* bacterial endospores) on inanimate objects.

Section 5.22 ***Disinfecting Solution**:* A chemical solution that kills infectious agents. The solution in particular is 1 part household bleach to 100 parts water (1:100). This solution is an extremely effective anti-bacterial and viruscidal agent.

Section 5.23 ***Engineering Controls**:* Means controls (sharps disposal containers, self-sheathing needles, safer medical devices, such as sharps with engineered sharps injury protections and needle-less systems) that isolate or remove the bloodborne pathogens hazard from the workplace. (OSHA)

Section 5.24 ***Enteric Precautions**:* A system of precautions to prevent transmission of disease by fecal/oral route.

Section 5.25 ***Etiologic Agent**:* A living organism that may cause human disease. (NFPA 472)

Section 5.26 ***Exposure Incident***: Means a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that results from the performance of an employee's duties. (OSHA)

Potential blood/body fluid exposures to prehospital personnel fall into three general categories, all of which involve blood or blood components, airborne pathogens, or other potentially infectious material as the vehicle.

a. A puncture cut from any sharp object previously contaminated with blood or blood component containing body fluid constitutes a potential exposure.

   Examples: Accidental needle sticks, test tube glass sliver cuts, cuts from vehicle wreckage where blood contamination exist (broken glass and sharp metal).

b. Contamination with blood or blood component containing body fluid on any exposed area of the body where there is broken or non-intact skin constitutes a potential exposure.

   Examples: Blood contamination of hands or arms where cuts, nicks, open wounds, severe chapping, or open hangnails exist or a splash onto the face where open acne lesions or cold sores exist.

c. Contamination with blood or blood component containing body fluid to any mucous membrane surface constitutes a potential exposure.

   Example: A splash or splatter that introduces blood into the mucous membrane lining of the eyes, nose or mouth.

   NOTE: Contamination of unbroken intact skin by blood or blood component containing body fluids does NOT constitute an exposure as no evidence of percutaneous transmission of any virus has ever been demonstrated.

Section 5.27 ***Fluid Resistant Clothing**:* Clothing designed and constructed to provide a barrier against accidental contact with body fluids.

Section 5.28 ***Hand-washing Facilities***: Means a facility providing an adequate supply of running potable water, soap and single use towels or hot air drying machines. (OSHA)

Section 5.29 ***HBV**:* Means hepatitis B virus. (OSHA)

Section 5.30 ***HCV**:* Means hepatitis C virus. (OSHA)

Section.5.31 ***Health Care Worker**:* An employee of a health care facility including, but not limited to, nurses, physicians, dentists, and other dental workers, optometrists, podiatrists, chiropractors, laboratory and blood bank technologists and technicians, research

laboratory scientists, phlebotomists, dialysis personnel, paramedics, emergency medical technicians, firefighters, law enforcement officers, medical examiners, morticians, housekeepers, laundry workers, and others whose work may involve direct contact with body fluids from living individuals or corpses.

Note: This definition includes firefighters and law enforcement officers, due to potential for direct contact with blood and other fluids during firefighting, rescue, extrication, capture and restraint of suspects and other emergency response activities.

Section 5.32 ***Hepatitis**:* Inflammation or swelling of the liver. Certain drugs, toxins or infectious agents, including viruses, can cause hepatitis. Hepatitis caused by viruses includes hepatitis A, B, C, D, E and other, as yet unclassified, types of hepatitis.

Section 5.33 ***HIV*****:** Means human immunodeficiency virus. (OSHA)

Section 5.34 ***Host:*** A person that can harbor or nourish a disease-producing organism. The host is infected.

Section 5.35 ***Human Immunodeficiency Virus:*** The causative agent of AIDS. HIV type 1 (HIV-1) causes most cases of AIDS. A second virus, HIV-2, is a less common cause of the disease.

Section 5.36 ***Incubation Period**:* The time from exposure to the disease until the first appearance of symptoms.

Section 5.37 ***Index Case***: Means any individual, living or dead, whose blood or other potentially infectious materials may be a source of occupational exposure to the employee. Examples include, but are not limited to, hospital and clinic patients, clients in institutions for the developmentally disabled, trauma victims, clients of drug and alcohol treatment facilities, residents of hospices and nursing homes, human remains, and individuals who donate or sell blood or blood components. Index case is synonymous with source individual.

Section 5.38 ***Infectious Products**:* This term identifies blood, body fluids containing gross visible blood and other potentially infectious materials, contaminated sharps and contaminated clothing/linens.

Section 5.39 ***Infectious Wastes**:* Blood and blood products, pathological wastes, microbiological wastes, and contaminated sharps. (MMWR)

Section 5.40 ***Morbidity and Mortality Weekly Report (MMWR)**:* A weekly publication from the Centers for Disease Control presenting up-to-date information on communicable diseases.

Section 5.41 ***Needle Stick**:* A parenteral exposure with a needle contaminated from patient use.

Section 5.42 ***Needle-less System**:* Means a device that does not use needles for:

(1) The collection of bodily fluids or withdrawal of body fluids after initial venous or arterial access is established;

(2) The administration of medication or fluids; or

(3) Any other procedure involving the potential for occupational exposure to bloodborne pathogens due to percutaneous injuries from contaminated sharps. (OSHA)

Section 5.43 ***Occupational Exposure**:* Means reasonably anticipated skin, eye, mucous membrane or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties. (OSHA)

Section 5.44 ***Occupational Illness**:* An illness or disease contracted through or aggravated by the performance of the duties, responsibilities, and functions of the employee.

Section 5.45 ***Other Potentially Infectious Materials (OPIM)*:** Means

1) The following human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids; (OPIM does not include tears, sweat, saliva, urine, vomitus, stool, nasal secretions and sputum unless they contain gross visible blood.)

2) Any unfixed tissue or organ (other than intact skin) from a human (living or dead); and

3) HIV-containing cell or tissue cultures, organ cultures, and HIV- or HBV-containing culture medium or other solutions; and blood, organs, or other tissues from experimental animals infected with HIV or HBV. (OSHA)

Section 5.46 ***Parenteral**:* Indicates the piercing of skin or mucous membranes through such events as needle sticks, human bites, cuts, and abrasions. (OSHA)

Section 5.47 ***Patient**:* This term means any individual, living or dead, whose body fluids, blood, tissues, or organs may be a source of exposure to the employee. Examples include but are not limited to: hospital and clinic patients, clients in institutions for the mentally challenged, trauma victims, clients of drug and alcohol treatment facilities, residents of hospices and nursing homes, human remains prior to embalming, and individuals who donate or sell blood or blood components.

Section 5.48 ***Personal Protective Equipment (PPE)**:* This is the specialized clothing or equipment worn by an employee to protect him/her from a hazard. General work clothes (e.g., uniforms, pants, shirts or blouses) are not intended to function as protection against a hazard and are not considered to be personal protective equipment. (OSHA)

Section 5.49 ***Regulated Waste***: Means liquid or semi-liquid blood or other potentially infectious materials; contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed; items that are caked with dried blood or other potentially infectious materials and are capable of releasing these materials during handling; contaminated sharps; and pathological and microbiological wastes containing blood or other potentially infectious materials. (OSHA)

Section 5.50 ***Sharps**:* This term identifies any object which can penetrate the skin including, but not limited to, needles, broken blood or capillary tubes, knives, or metal and glass as found at an automobile accident.

Section 5.51 ***Sharps with Engineered Sharps Injury Protections***: Means a non-needle sharp or a needle device used for withdrawing body fluids, accessing a vein or artery, or administering medications or other fluids, with a built-in safety feature or mechanism that effectively reduces the risk of an exposure incident. (OSHA)

Section 5.52 ***Source Indvidual***: Means any individual, living or dead, whose blood or other potentially infectious materials may be a source of occupational exposure to the employee. Examples include, but are not limited to, hospital and clinic patients; clients in institutions for the developmentally disabled; trauma victims; clients of drug and alcohol treatment facilities; residents of hospices and nursing homes; human remains; and individuals who donate or sell blood or blood components. Source individual is synonymous with index case. (OSHA)

Section 5.53 ***Sterilize:*** Means the use of a physical or chemical procedure to destroy all microbial life including highly resistant bacterial endospores. (OSHA)

Section 5.54 ***Universal Precautions****:* An approach to infection control. According to the concept of Universal Precautions, all human blood and certain human body fluids are treated as if known to be infectious for HIV, HBV, and other bloodborne pathogens. (OSHA)

Section 5.55 ***Virulence****:* The disease-evoking power of a microorganism in a given host.

Section 5.56 ***Virus****:* A microorganism usually only visible with the electron microscope. Viruses normally reside within other living (host) cells, and cannot reproduce outside of a living cell.

Section 5.57 ***Window Phase****:* The time between exposure to a disease until positive test results can be obtained.

Section 5.58 ***Work Practice Controls****:* This means controls that reduce the likelihood of exposure by altering the manner in which a task is performed (i.e., prohibiting the recapping of needles by a two-handed technique). (OSHA)

Section 5.59 ***Workers Compensation Incident Report***: *(Injury and Illness Initial Accident Form*): This is the accident report form used by the City of Greenville. This report is sometimes referred to as the "Employee Accident Report." This report is required to be completed by the injured/affected employee following any on-the-job accident or injury and submitted to their supervisor or proper channels.

Article VI Exposure Determination

Section 6.1 Employees incur risk each time they are exposed to bloodborne or airborne pathogens. Any exposure incident may result in infection and subsequent illness. The exposure determination is made without regard to the use of personal protective equipment.

Section 6.2 Three categories of Fire/Rescue duties/tasks are identified by the following parameters:

Category I - Those tasks which involve procedures that will provide actual blood exposure. Examples include, but are not limited to: extricating the injured, removing victims of a fire, providing first aid care, and invasive ALS procedures.

Category II - Those tasks that by themselves entail no blood exposure, though the individuals assigned to the task may be called upon to perform an unplanned Category I task.

Category III- Those tasks with no blood exposure.

Section 6.3 Category I tasks are:

a. Performance of EMS duties, regardless of credential level.
b. Performance of non-emergency first aid to victims of minor incidents.
c. Performance of rescue/extrication for victims of entrapment.

Section 6.4 Category II tasks are:

a. Performance of command and control functions on the scene of emergency incidents.
b. Performance of fire prevention and inspection duties.
c. Performance of departmental training functions.
d. Performance of departmental administrative operations.
e. Performance of EMS management operations.

Section 6.5 Category III tasks are:

a. Performance of clerical and secretarial functions of department.

Section 6.6 The positions within the Greenville Fire/Rescue Department whose duties include the tasks as identified in sections 4.3 through 4.5 are as follows:

Category I	**Category II**	**Category III**
F/R Trainee	Battalion Chief	Clerk/Typist I/II
F/R I	Fire Prevention Manager	Admin. Assistant
F/R II	Fire Prevention Specialist	Admin. Secretary
EMS Specialist	EMS Manager	
Lieutenant	Fire Training Coordinator	
Captain	Chief	
	Deputy Chief	

NOTE: The above exposure determination is necessary in order to assure that the employees who hold Category I and II positions are included in the training programs, are provided with personal protective equipment, and where appropriate, are provided with post exposure follow up and are included in the HBV vaccination program. Furthermore, this determination has been made without taking into consideration the use of personal protective clothing or equipment.

Article VII Prevention Guidelines

Section 7.1 Body Substance Isolation shall be observed to prevent contact with blood and other potentially infectious materials, unless those precautions would interfere with the proper delivery of health care or public safety services in a particular circumstance, or would create a significant risk to the personal safety of the worker. All blood or other

potentially infectious materials will be considered infectious, regardless of the perceived status of the source victim.

NOTE: It is intended that the exemption stated in the latter portion of the above paragraph (7.1) will serve as an exemption to the use of personal protective equipment in appropriate cases and is not intended to provide an excuse for complete non-adherence to the overall concept of Body Substance Isolation precautions. Administration recognizes that on occasion particular circumstances arise in which the use of personal protective equipment may interfere with the proper delivery of health care or public safety services or create a significant risk to the personal safety of the worker. These particular circumstances shall be taken to mean extraordinary situations that are unexpected and threaten the life or safety of the patient or worker.

The following examples illustrate several scenarios to which the exemption may apply:

1) The EMT's glove tears in the midst of a critical and life saving task.

2) A sudden change in patient status, as when an apparently stable patient unexpectedly begins to hemorrhage profusely, putting the patient's life in immediate jeopardy.

3) A firefighter rescues an individual who is not breathing from a burning building and discovers that his or her resuscitation equipment is lost or not available, and he or she must administer CPR immediately.

4) A patient who is bleeding unexpectedly attacks an employee with a knife, threatening the safety of the employee and/or coworkers.

In evaluating each of the above situations it may be judged that the requirement to don personal protective equipment is outweighed by the critical need to saving the patient's life or preventing significant risk to the employee's personal safety. The employee who takes advantage of this exemption in a particular circumstance must continue to take steps to reduce his or her risk. Moreover, as soon as the situation changes, for example, when a properly protected coworker is available to relieve the employee, the criticality of the patient's condition decreases, or the violent patient subdued, the employee is expected to implement use of full Body Substance Isolation precautions.

While "interfere with" may be construed to encompass a broad range of intrusions into one's task performance, the Greenville Fire/Rescue Department intends for this term to be interpreted in the strictest sense, that is, the prevention of proper delivery of health care or public services. Therefore, the administration does not feel that concerns about appearance, perceived low risk, or personal perception of interference are acceptable reasons for not using personal protective equipment.

Finally, employees must exercise their professional judgment in making that decision and should be aware that they will be asked the reasons for their course of action.

Section 7.2 Greenville Fire/Rescue department utilization of engineering and work practice

controls include but are not limited to:

- PPE
- Needle save devices
- Needle-less devices
- Sharps containers
- High efficiency air filtration
- Laundry management procedures
- Enforcement of the Exposure Control Plan
- Periodic compliance monitoring

Where occupational exposure remains after institution of these controls and other controls, personal protective equipment will also be utilized in accordance with section 8.

Section 7.3 While treating victims of possible injury or illness, gloves shall be donned immediately prior to the administration of care, NOT during travel to the scene. Gloves are not required for all patient contact. Gloves are required whenever there is a reasonable risk of contact with blood, OPIM or other body substances.

Section 7.4 Employees shall wash their hands immediately or as soon as possible after the removal of gloves or other personal protective equipment and after hand contact with blood and other potentially infectious materials.

Section 7.5 When hand-washing facilities are not available, the employee shall use the antiseptic hand cleanser in conjunction with a clean cloth or paper towels. When the employee has washed his or her hands using the antiseptic hand cleanser, their hands shall also be washed using soap and running water as soon as feasible.

Section 7.6 Hands shall be washed even if gloves or an antiseptic hand cleanser were used after all patient contacts, cleaning procedures, disinfecting procedures and truck / equipment inspections.

Thoroughly wash hands with soap and water upon returning to the station in all cases.

a. Use soap and running water
b. Scrub vigorously for at least 15 seconds
c. Wash ALL surfaces
d. Clean under fingernails
e. Rinse well
f. Dry hands well

Handwashing must occur following calls, treatment of patients and after the handling of equipment. Handwashing after calls, after treatment of patients and after handling equipment must not be done in food preparation areas.

Section 7.7 Employees will wash their hands and any other skin with soap and water, or flush mucous membranes with water immediately or as soon as feasible following contact with blood or other potentially infectious materials.

Section 7.8 All personal protective equipment (PPE) is to be removed immediately upon leaving the work area, completing the designated task or as soon as possible if overtly

contaminated. These items shall be placed in an appropriately designated area or container (example: waste or sharps bin in ambulance, contaminated waste bag at the hospital or the station, cold liquid sterilization at the hospital, etc.) for storage, washing, decontamination, or disposal. Gloves shall be removed prior to driving departmental vehicles.

Section 7.9 Contaminated needles and other contaminated sharps shall not be sheared, bent, broken, recapped, or resheathed by hand. Contaminated needles shall not be removed from disposable syringes. Non-contaminated needles, such as multi-dose syringes, may be recapped utilizing the one handed technique.

Section 7.10 Immediately (at the site of use) or as soon as possible after use, contaminated sharps shall be placed in appropriate containers until properly reprocessed. These containers shall be:

a. Puncture resistant,
b. Labeled or color-coded in accordance with this policy,
c. Leak proof on the sides and bottom, and
d. In accordance with the requirements set forth in Article XIV.

Section 7.11 Bag-valve-masks (BVM), demand valves (DV) and/or respironics devices should be used in all instances where ventilation or assisted ventilation is required. If BVM or any other device should fail, mouth to mask, or mouth to mouth ventilation is to be performed.

Section 7.12 Eating, chewing, drinking, smoking, use of tobacco products applying cosmetics or lip balm, and handling contact lenses are prohibited in the ambulances, and any other work area where there is a potential for occupational exposure. It is the intention of this rule that nothing shall be consumed, put in the mouth or any mucous membrane and/or in eyes.

Section 7.13 Food and drink can only be carried in the front ambulance cab and / or in exterior ambulance compartments. No food or drink shall be kept or carried in the patient compartment.

Section 7.14 All procedures involving blood or other potentially infectious materials shall be performed in such a manner as to minimize splashing, spraying and aerosolization (the generation of droplets) of these substances.

Section 7.15 Specimens of blood or other potentially infectious materials shall be placed in a container that prevents leakage during collection, handling, processing, storage, transport, or shipping.

a. The container for storage, transport, or shipping shall be labeled or color-coded according to Article XIV, and closed prior to being stored, transported, or shipped. If the employee uses Body Substance Isolation procedures, then labeling or color-coding is not necessary, provided the containers used are standard and recognizable as containing specimens (i.e., vacutainer tubes).

b. If outside contamination of the primary container occurs, the primary container shall be placed within a second container, which prevents leakage during handling, processing, storage, transport, or shipping and shall be

decontaminated as necessary.

c. If the specimen could puncture the primary container, the primary container shall be placed within a secondary container that is puncture-resistant in addition to the above characteristics.

Section 7.16 Vaccination Procedures for Hepatitis B

The Greenville Fire/Rescue Department will make available to any Category I and II employee (as determined in Article IV) the complete hepatitis B vaccine series and post-vaccine testing.

Vaccinations will be made available to all Category I & II employees within the first 10 days of employment or placement into a Category I or II position. Bloodborne pathogens training is to be conducted prior to vaccination. Vaccines will be provided at no cost to employees and will be provided during normal business hours. Any cost incurred by an employee in receiving the vaccination, such as transportation to and from facility to receive vaccination and time while off duty to receive the vaccination, shall be reimbursed.

The vaccination schedule is as follows:

First Dose:	Initial date
Second Dose:	1 month after first dose
Third Dose:	5 months after second dose
Testing:	1-2 months after third dose

NOTE: Persons who do not respond to the primary vaccine series should complete a second 3-dose vaccine series or be evaluated to determine if they are HBsAG-positive. Revaccinated persons should be retested at the completion of the second vaccine series.

Persons who prove to be HBsAG-positive should be counseled regarding how to prevent HBV transmission to others and regarding the need for medical evaluation.

Nonresponders to vaccination who are HBsAG-negative should be considered susceptible to HBV infection and should be counseled regarding precaution to prevent HBV infection and the need to obtain HBIG prophylaxis for any known or probable parenteral exposure to HBsAG-positive blood. (CDC, MMWR, June 29, 2001, “Updated U.S. Public Heath Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Post Exposure Prophylaxis” as referenced in OSHA 1910.1030(f)(1)(ii)(D) and OSHA CPL 2-2.69, XIII, F, 5).

Employees who elect to receive the Hepatitis B Vaccine series must sign the “Hepatitis B Vaccine Consent Form”, prior to receipt of their first dose. (Attachment 2).

Employees have the option to decline the vaccination series, but are required to read, complete and sign the “Hepatitis B Vaccine Declination Form” (Attachment 2).

An employee who initially declines the vaccination may exercise their right to receive vaccine at a future date as long as their position is identified in Category I or Category II.

The Designated Officer shall ensure that the healthcare professional responsible for the employee's Hepatitis B vaccination has a copy of 29 CFR 1910.1030.

Article VIII Personal Protective Equipment

Section 8.1 Provision and Use. When there is a potential for occupational exposure, the Fire/Rescue Department shall provide, at no cost to the employee, and assure the use of appropriate personal protective equipment such as, but not limited to, gloves, gowns, eye protection, masks, resuscitation bags, pocket ventilation masks, or other ventilator devices.

Section 8.2 Use. Whenever there is a reasonable risk of exposure to blood or other potentially infectious materials, the employee shall use the appropriate personal protective equipment. The employee may *temporarily* and *briefly* decline to use personal protective equipment when, under *rare* and extraordinary circumstances, it is the employee's professional judgment that in the specific instance its use would have prevented the delivery of health care or public safety services or would have posed an increased hazard to the safety of the worker or co-worker (See Section 7.1)

For each event that an employee exercises the judgment NOT to wear PPE, their supervisor shall perform a thorough investigation and the event and circumstances documented and forward to the departments designated officer. A determination shall be made as to whether or not changes are warranted and if necessary, put in place immediately to avoid further occurrence.

Section 8.3 Accessibility. The Shift Supervisor shall assure that appropriate personal protective equipment in the appropriate size is readily available in the ambulances, on fire apparatus in the stations and / or issued to the employees.

Section 8.4 Repair and Replacement. The Fire/Rescue Department shall repair or replace required personal protective equipment required by this policy.

Section 8.5 Gloves. Gloves shall be worn when the employee has the potential for their hands to have direct skin contact with blood, other potentially infectious material, mucous membranes, non-intact skin, and when handling items soiled with blood and other potentially infectious materials. Hypoallergenic gloves or other suitable alternatives shall be readily accessible to those employees who are allergic to the gloves that are normally provided. Employees who possess latex hypersensitivity must inform their shift supervisor. The Greenville Fire/Rescue Department will provide latex and non-latex type gloves for personnel.

Disposable (single use) gloves, such as surgical or examination gloves shall be replaced as soon as possible when visibly soiled, torn, punctured or when their ability to serve as a barrier is compromised. They shall NOT be washed or disinfected for re-use.

Heavy-duty rubber or vinyl gloves should be used when cleaning the unit or equipment and may be disinfected for re-use. If heavy-duty rubber or vinyl gloves are not available, then disposable gloves shall be used under the same rules as stated in

previous paragraph.

Section 8.6 Masks, Eve Protection, Face Shields. Masks and eye protection, or chin-length face shields shall be worn whenever splashes, spray, splatter, droplets, or aerosols of blood or other potentially infectious material may be generated (i.e. suctioning) and there is a potential for eye, nose, or mouth contamination.

Section 8.7 Gown, Aprons, and Other Protective Bodv Clothing. Appropriate protective clothing shall be worn when the employee has the potential for occupational exposure. The type and characteristics will depend upon the tasks and degree of exposure anticipated; however, the clothing selected shall form an effective barrier. Full uniforms comply with the requirements of this rule as a primary barrier.

Section 8.8 Guide to selection and tasks requiring personal protective equipment. (Refer to Attachment 1)

Article IX Cleaning and Disinfecting

Section 9.1 All equipment and environmental and working surfaces shall be properly cleaned and disinfected after contact with blood or other potentially infectious materials.

Section 9.2 Ambulance interiors, and any other applicable work surfaces shall be decontaminated with designated disinfectant solution or a bleach solution of 1:100 after completion of procedures, when surfaces are overtly contaminated, immediately after any spill of blood or other potentially infectious materials, and at the beginning of each work shift.

Section 9.3 Equipment that may become contaminated with blood or other potentially infectious materials shall be checked routinely (on weekly check day) and prior to placing into service, and shall be decontaminated as necessary.

Section 9.4 Reusable items contaminated with blood or other potentially infectious materials shall be decontaminated using the designated disinfectant solution or a 1:100 bleach solution prior to washing and/or processing.

Section 9.5 Broken glassware or other sharps that may be contaminated shall not be picked up directly with the hands. It shall be cleaned up using mechanical means, such as a brush and dustpan, a vacuum cleaner, tongs, cotton swabs or forceps.

Section 9.6 All regulated waste destined for disposal shall be placed in leak proof, closable containers or bags that are color coded (red) or labeled (BIOHAZARD or with BIOHAZARD symbol).

Section 9.7 Immediately after use, sharps shall be disposed of in closable, puncture resistant, disposable containers which are leak proof on the sides and bottom and that are appropriately labeled or color coded. These containers shall be easily accessible to personnel and located in the immediate area of use. These containers shall be replaced routinely or when they reach the manufacturer's "full" mark.

All other biohazard waste shall be properly packaged (red leak proof bags) and disposed of at the designated depository located in the Emergency Department of the hospital.

As the need arises for the disposal of sharps containers, the EMS Specialist in charge (EMS Units) or the officer in charge (engines) shall deposit the sharps container in the designated sharps depository located in the Emergency Department of the hospital.

Never manually open, empty, or clean reusable contaminated sharps disposal containers.

Section 9.8 The following guidelines shall be followed when contamination of the ambulance and/or patient care equipment occurs:

a. Heavy-duty utility gloves should be worn when cleaning and disinfecting infectious materials. (Section 8.5)

b. Ambulances shall be routinely cleaned daily at the beginning of each shift and after each call.

c. Passenger/patient areas and seats in vehicles and on apparatus which have come in contact with contaminated clothing, waste or other matter shall be scrubbed with a disinfectant or a bleach and water solution (1:100), rinsed off and air dried.

d. Use 1:100 bleach solution or cold liquid sterilization according to manufacturer's instructions for cleaning reusable items such as, but not limited to, laryngoscope blades, suction equipment, stethoscopes, etc.

e. Large EMS equipment such as traction splints, backboards, blood pressure cuffs, MAST garments, straps, etc., must have scrupulous mechanical cleaning to remove all protein material (i.e. blood, vomit, stool, urine, or sputum). This cleaning should be done as soon as possible after use, to prevent drying of the material and to lower the number of microorganisms. It is a requirement to immediately use a disinfectant / detergent solution, hot water and air-drying.

f. Disposable bag-valve-masks are exchanged at the receiving hospital for replacements.

g. The disinfectant solution of bleach and water (1:100 household bleach to water) is effective for 24 hours. Mix new solution daily and label the solution date and time.

h Exchange soiled linens with the receiving hospital, depositing the soiled linens into the appropriate bin following hospital rules. While "in-house" at the Greenville Fire/Rescue Department, bag all linens contaminated with scabies/lice or dripable or flakable blood or body fluids in a color coded (red) or labeled bag.

Cleaning of contaminated equipment shall at no time take place in food preparation areas.

Section 9.9 Upon returning to quarters, any contaminated equipment shall be removed and replaced with clean equipment if possible. The contaminated equipment shall be cleaned and replaced on the unit as soon as possible.

Section 9.10 Upon returning to quarters, or while at hospital, supplies of PPE shall be replenished.

Section 9.11 Heavy-duty rubber or vinyl gloves should be used when cleaning the unit or equipment and may be disinfected for re-use. If heavy-duty rubber or vinyl gloves are not available, then disposable gloves shall be used under the same rules as stated in Section 8.5. Other PPE will be used depending on splash or spill potential.

Section 9.12 Eating, drinking, smoking, handling contact lenses, or applying cosmetics or lip balm is prohibited during cleaning or decontamination procedures.

Section 9.13 Disinfections will be performed with a department-approved disinfectant (which meets applicable regulations) or with a 1:100 bleach solution.

Section 9.14 Delicate equipment (radios, cardiac monitors, computers etc.) shall be wiped clean of any debris using hot soapy water, then wiped with clean water and dried or wiped with disinfectant or 1:100 bleach solution and dried.

Section 9.15 Scene Clean Up

a. Prior to the removal of PPE, personnel remaining on the scene of a medical emergency should carefully search for and remove contaminated materials (any disposable materials used in patient care that contains blood or other body fluids).

b. Materials shall be taken back to the station for disposal in infectious waste containers if the materials were not disposed of in the ambulance waste container prior to its departure.

c. All contaminated sharps must be disposed into puncture resistant containers.

Article X Laundry

Section 10.1 Employee's laundry that is contaminated with blood or other potentially infectious materials or may contain contaminated sharps shall be treated as if it were contaminated and shall be handled as little as possible and with a minimum of agitation.

Section 10.2 Contaminated laundry shall be bagged at the location where it was used (station) in a color coded (red) labeled leak proof bag or in a bag that is labeled “BIOHAZARD – Contaminated Laundry”.

Section 10.3 The bags shall then be transported to a station which is equipped with commercial laundry equipment or a designated commercial laundry.

Section 10.4 Contaminated work clothes (uniforms, jump suits, t-shirts, socks, etc) shall be removed and exchanged for clean clothes. The employee must shower if body fluids were in contact with skin under their work clothing.

Section 10.5 To avoid the possibility of spreading infectious disease by crosscontamination, contaminated protective clothing, station/work uniforms or other clothing **shall not be taken home**. Laundering must be done at the station or at a designated commercial

laundry provided that they are notified prior to delivery that said clothing is contaminated with potentially infectious material. Guidance from a supervisor is available to determine situations where commercial laundry facilities are to be utilized. Laundering should be done as soon as reasonably possible. Clothing can be laundered in a normal manner according to the clothing manufacturers instructions. Under no circumstances should you use chlorinated bleaches on uniforms or turnout clothing. Disinfectants and detergents shall be approved by and registered with the U.S. EPA.

Section 10.6 "In-house" laundry workers will wear protective gloves and other appropriate personal protective equipment to prevent occupational exposure during handling and sorting.

Section 10.7 Shift personnel shall maintain a complete change of clothing in the station in the event they contaminate the duty uniform.

Section 10.8 Contaminated structural firefighting gear (turnout coats/bunker pants, gloves, hoods, helmet linings, and ear flaps) will be cleaned according to manufacturer's recommendations found on attached labels. Normally this will consist of a wash with hot soapy water followed by a rinse with clean water. Follow manufacturer's recommendations for drying.

Chlorine bleach may impair the fire-retardant properties of structural firefighting gear and will not be used.

Section 10.9 Contaminated boots will be brush-scrubbed with a hot solution of soapy water, rinsed with clean water, and allowed to air dry.

Article XI Post Exposure Evaluation and Follow Up

Section 11.1 Any employee exposed to potentially infectious material will immediately wash the exposed area with soap and water, or normal saline eyewash if the eyes are involved.

Section 11.2 Any employee having a potential occupational communicable disease exposure will immediately report the exposure to their shift supervisor so that arrangements may be made for personnel changes while exposed employee seeks post exposure evaluation.

Section 11.3 Any employee with a valid exposure to blood or other potential infectious material as determined by their shift D.O. or department D.O. will report to Pitt County Memorial Hospital Emergency Department for the initial phase of the post exposure follow-up. Upon arrival the employee is to follow the "Pitt County Memorial Hospital Infection Control Policy, G7, Emergency Response Employee (ERE) and Good Samaritan: Management of Exposure to Blood or Body Fluids." (Attachment 3)

Section 11.4 Upon release from the emergency department, the employee shall complete a "Worker's Compensation Incident Report" (Attachment 5) as supplied by the City of Greenville and submit it to their immediate supervisor. Employee shall also complete a copy of the Greenville Fire/Rescue Department's "Infectious Disease/Blood/Body Fluid Exposure Form" (Attachment 6) and remit to the EMS Manager/designated officer.

Section 11.5 Employees will complete the appropriate reports, as identified in 11.3 and 11.4 above for any of the following exposures:

- Contaminated needle-stick injury.
- Break in the skin caused by a potentially contaminated object.
- Splash of blood or other potentially infectious material (OPIM) onto eyes, mucous membranes, or non-intact skin.
- Mouth-to-mouth resuscitation without a pocket mask or shield.
- Any confirmed or suspected exposure to tuberculosis.
- Other exposure that the employee may feel is significant.

Section 11.6 For employees who have been advised by the attending physician that the source tested negative to HIV, HBV, and HCV, no additional testing and post exposure follow up is necessary.

Section 11.7 If the source patient has tested positive to any of the previously listed diseases, and the attending physician recommends Post Exposure Prophylaxis, then the employee must report immediately to the designated officer.

Section 11.8 The D.O. shall ensure that the most current recommendations from the U.S. Public Health Services for the Management of Occupational Exposures are followed.

Section 11.9 The EMS Manager shall subscribe to a service for updates to applicable guidelines. The Exposure Control Committee and employees shall be advised of any plan changes. The EMS Manager shall verify in writing that all medical facilities are following the most recent guidelines.

Section 11.10 The confidential medical evaluation and follow-up (whether provided at PCMH or designated medical facility) will include at least the following elements:

a. Documentation of the route(s) of exposure, and the circumstances under which the exposure incident occurred. (PCMH)

b. Identification and documentation of the source individual, unless the employer can establish that identification is infeasible or prohibited by state or local law.

1. The source individual's blood shall be tested as soon as feasible and after consent is obtained in order to determine HIV, HBV and HCV infectivity. If consent is not obtained, the employer shall establish that legally required consent cannot be obtained. When the source individual's consent is not required by law, the source individual's blood, if available, shall be tested and the results documented. (PCMH)

2. When the source individual is already known to be infected with HIV, HBV or HCV, testing for the source individual's known HIV, HBV or HCV status need not be repeated. (PCMH)

3. Results of the source individual's testing shall be made available to the exposed employee, and the employee shall be informed of applicable laws and regulations concerning disclosure of the identity and infectious status of the source individual. (PCMH)

c. Collection and testing of blood for HIV, HBV, HCV and syphilis serological Status.

1. The exposed employee's blood shall be collected as soon as feasible and tested after consent is obtained. (PCMH)

2. If the employee consents to baseline blood collection, but does not give consent at that time for HIV serologic testing, the sample shall be preserved for at least 90 days. (PCMH will preserve sample) The EMS Manager must confirm in writing that PCMH will preserve samples as needed. If, within 90 days of the exposure incident, the employee elects to have the baseline sample tested, such testing shall be done as soon as feasible. (Employee must notify PCMH to conduct testing)

d. Post Exposure Prophylaxis, when medically indicated, as recommended by the U.S. Public Health Service (to be provided by designated medical facility or PCMH).

e. Counseling (PCMH and designated medical facility).

f. Evaluation of reported illnesses (PCMH and designated medical facility).

For all Post Exposure Evaluations and follow-ups the Fire/Rescue Department shall ensure that the healthcare professional providing services is provided with the following information:

a. A copy of 29 CFR 1910.1030, OSHA's Bloodborne Pathogens Standard. (Employer may verify that healthcare professional has a current copy through written confirmation)

b. A copy of this policy and its appendices. (A copy shall be submitted upon any revisions made, to the Medical Director at PCMH and designated medical facility)

c. A description of the affected employee's duties as they relate to the employee's occupational exposure. (Provided through employee completion of PCMH's Blood/Body Fluid Exposure Form)

d. Documentation of the route(s) of exposure and circumstances under which exposure occurred. (Provided through employee completion of PCMH's Blood/Body Fluid Exposure Form)

e. Results of the source individual's blood testing, if available (PCMH attending physician will coordinate communication of results to the designated medical facility in accordance with applicable laws); and

f. All medical records relevant to the appropriate treatment of the employee including vaccination status which are the employer's responsibility to maintain. (Designated medical facility provides vaccinations and therefore has immediate access to these records).

Section 11.11 For each evaluation under this article, the Fire/Rescue Department shall obtain and provide the employee with a copy of the evaluating physician's written opinion within

15 days (Clarification: 15 Working days, per OSHA CPL2-2.69, XIII(F)(23)) of the completion of the evaluation. (Attachment 7) The written opinion shall be limited to the following information:

a. The healthcare professional's written opinion for Hepatitis B vaccination shall be limited to whether Hepatitis B vaccination is indicated for an employee, and if the employee has received such vaccination

b. The healthcare professional's written opinion for post exposure evaluation and follow up shall be limited to the following information:

1. That the employee has been informed of the results of the evaluation.

2. That the employee has been told about any medical conditions resulting from exposure to blood or other potentially infectious materials which require further evaluation or treatment.

3. All other findings or diagnoses shall remain confidential and shall not be included in the written report.

Section 11.12 The Designated Officer will perform or refer employees for exposure control retraining, counseling, or stress management. Spousal counseling will also be available.

Section 11.13 All post exposure evaluation and treatment will be provided at no cost to the employee and will be made available to the employee at a reasonable time and place, during working hours if possible.

Section 11.14 In addition to the medical evaluation and post exposure follow-up for the bloodborne pathogens specified in this plan (HIV, HBV, HCV and syphilis), employees will be afforded evaluation and post exposure follow up for ANY occupational exposure to bloodborne pathogens not specified in this plan when deemed medically necessary.

Article XII Recordkeeping

Section 12.1 Medical Records: It is important to remember that all records regarding infectious disease, exposures/contaminations, testing, treatment and follow up are **confidential**. Furthermore, medical records, medical authorizations, immunization information, declinations, workers compensation reports, OSHA reports, and NCOSHA reports are not public records subject to disclosure under NCGS § 132-1. Release of medical information shall only occur with written consent of the employee or in accordance with other guidelines within this policy. An employee's complete record shall be available to the employee upon request and copies provided at no cost.

The EMS Manager/Designated Officer shall establish and maintain an accurate record for each employee. This record shall include:

a. The name and social security number for the employee.

b. A copy of the employee's hepatitis B vaccination records to include post-vaccine antibody testing, medical records relative to the employee's ability to receive vaccination or to post-exposure evaluation following an exposure incident.

c. A copy of the results of physical examinations, medical testing, and follow-up procedures as they relate to the employee's ability to receive vaccination or to post-exposure incident.

d. The employer's copy of the physician's written opinion for vaccination and/or post-exposure purposes.

e. A copy of the information that was provided to the physician as was required in Article XI, Section 11.6.

f. Refusals, in writing, of any immunizations, treatments and/or follow-up.

The City of Greenville and the Fire/Rescue Department shall assure that employee medical records are:

a. Kept confidential by designating the EMS Manager as the documents controller and securing them in the EMS Manager's office.

b. Not disclosed or reported to any person within or outside the workplace except as required by this policy or as may be required by law. (Exception Human Resource department)

c. Maintained for the length of employment, plus thirty years, except for those records of employees who are employed for less than one year, provided the records are given to the employee upon the cessation of their employment. (OSHA 1910.1020)

d. Made available, at no cost, to employees upon request.

Filing the exposure as a work related injury.

a. All exposures, valid or not, requiring medical payment must be filed under Workers' Compensation. The Fire / Rescue Administrative Secretary is responsible for processing the Form 19, Employer's Report of Employee's Injury or Occupational Disease to the Industrial Commission.

b. In order for medical bills relating to an exposure to be paid, the Administrative Secretary will need to complete and forward the Form 19 to the Benefits Administrator or Safety / Risk Manager. The Benefits Administrator is responsible for filing the claim with the City's current TPA.

c. The Workers' Compensation file for the exposure will be kept confidential. The employee's name will not be recorded on the OSHA log. Once the claim is processed all incoming bills with employees names will be "blacked out". Identification will only be made through the hospitals coding system.

Section 12.2 Training Records: Training records shall document the following:

a. The date(s) of training

b. Contents or a summary of the training sessions

c. Instructor(s) name and qualifications

d. Name(s) of individual(s) attending, job title and category

It shall be the responsibility of the Fire/Rescue Training Coordinator to maintain the training records required by this plan. Training records shall be retained for three years from the date the training occurred. (Attachment 8)

Section 12.3 Sharps Injury Log: The Designated Officer shall establish and maintain a sharps injury log for the recording of percutaneous injuries from contaminated sharps. The information in the sharps injury log shall be recorded and maintained in such manner as to protect the confidentiality of the injured employee. (Attachment 9) The sharps injury log shall contain, at a minimum:

a. The type and brand of device involved in the incident,

b. The department or work area where the exposure incident occurred, and

c. An explanation of how the incident occurred.

d. The sharps injury log shall be maintained as required.

Section 12.4 OSHA 300 Log: The Designated Officer shall record on the OSHA 300 Log, the following as they pertain to bloodborne exposure incidents that are work-related:

a. Needlestick injuries and cuts from sharp objects that are contaminated with another person's blood or other potentially infectious material (as defined by 29 CFR 1910.1030) shall be recorded on the OSHA 300 Log as an injury. To protect the employee's privacy, DO NOT enter the employee's name on the OSHA 300 Log (see the requirements for privacy cases in paragraphs 1904.29(b)(6) through 1904.29(b)(9) of the OSHA regulatory text).

   The Designated Officer shall ensure that the OSHA 300 log is updated if the employee is later diagnosed with an occupationally acquired infectious bloodborne disease, and the case results in death, days away from work, restricted work, or job transfer. The update must include a description, which identifies the infectious disease and changes the classification of the case from an injury to an illness.

b. Splash or exposure to blood or other potentially infectious material without being cut or scratched shall be recorded on the OSHA 300 Log as an illness if:

   1. It results in the diagnosis of a bloodborne illness, such as, but not limited to HIV, hepatitis B, or hepatitis C; or

   2. It meets one or more of the recording criteria in section 1904.7 of the OSHA regulatory text.

Article XIII Information and Training

Section 13.1 All employees with Category I and II exposure potential shall participate in a training program.

Section 13.2 Training shall be provided at the time of initial employment in a Category I or Category II position and within one year thereafter.

Section 13.3 The training program shall contain the following elements:

a. An accessible copy of the regulatory text of 29 CFR 1910.1030, OSHA's Bloodborne Pathogen Standard.

b. A copy of this plan and an explanation of its contents.

c. A general discussion of the epidemiology and symptoms of bloodborne diseases (Attachment 10).

d. An explanation of the modes of transmission of bloodborne pathogens (Attachment 10).

e. An explanation of Greenville Fire/Rescue's exposure control plan and the means by which the employee can obtain a copy of the written plan.

f. An explanation for the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and other infectious materials.

g. An explanation of the use and limitations of practices that will prevent or reduce exposure including appropriate engineering controls, work practices, and personal protective equipment.

h. An explanation for the basis of selection of personal protective equipment.

i. Information on the types, proper use, location, removal, handling, decontamination and/or disposal of personal protective equipment.

j. Information on the hepatitis B vaccine, including information on its efficacy, safety, method of administration and the benefits of being vaccinated, and that the vaccine and vaccination will be offered free of charge.

k. Information on the appropriate actions to take and persons to contact in an emergency involving blood or other potential infectious materials.

l. An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and the medical follow-up that will be made available. Also information on the medical counseling that will be provided for exposed individuals.

m. An explanation of signs, labeling, and color coding used in conjunction with medical/infectious waste or contaminated items.

n. An opportunity for interactive questions and answers with the person conducting the training session.

Article XIV Communications of Hazards to Employees

Section 14.1 Warning labels shall be affixed to containers of medical/infectious waste, or containers used to store or transport blood or other potentially infectious products.

Section 14.2 Labels required by this section shall include the following legend:

BIOHAZARD

Section 14.3 These labels shall be fluorescent orange or orange-red or predominantly so, with lettering or symbols in a contrasting color.

Section 14.4 The required labels shall either be an integral part of the container or should be affixed as close as safely possible to the container by string, wire, adhesive or other method that prevents their loss or unintentional removal.

Section 14.5 Red bags or red containers may be substituted for labels on containers of medical/infectious waste.

Article XV Compliance Monitoring

Section 15.1 Compliance monitors, (Attachments 12A&B), will be completed on a weekly basis, on Saturdays, by each station officer.

Section 15.2 Station officers are responsible for completing the compliance monitor forms, immediately correcting findings and ensuring the health, safety and welfare of employees is maintained.

Section 15.3 Compliance monitoring forms are forward to the shift-designated officer for review and then to the department designated officer for review and file.

Article XVI Plan Review Criteria

Section 16.1 The Exposure Control Plan shall be reviewed and updated at least annually and whenever necessary to reflect new or modified tasks and procedures which affect occupational exposure and to reflect new or revised employee jobs with occupational exposure. The review and update of the plan shall also:

a. Reflect changes in technology that eliminate or reduce exposure to bloodborne pathogens; and

b. Document annually consideration and implementation of appropriate commercially available and effective safer medical devices designed to eliminate or minimize occupational exposure. (Attachments 11(A-E))

c. Include input from non-managerial employees responsible for direct patient care who are potentially exposed to injuries from contaminated sharps as to

the identification, evaluation, and selection of effective engineering and work practice controls. This input may be directed through the exposure control committee or through the Designated Officer.

d. Be the responsibility of the EMS Manager or his/her designee(s).

Article XVI Enforcement of Plan

Section 17.1 It shall be the duty and responsibility of each employee covered by this plan to adhere to the provisions of the plan. All employees shall comply with the Occupational Safety and Health Standards and all rules, regulations and orders issued pursuant to this Article, which are applicable to their own actions and conduct. NCGS § 95-130 (1). Any act which is not in accordance with this plan shall be investigated by and documented by the immediate supervisor, and disciplinary action shall be initiated in accordance with the City of Greenville's Personnel Policies, Resolution #1381, Article IX, Section 2.1.h. The immediate supervisor shall notify the EMS Manager of any infractions of this plan.

Nothing in this or any other provision of this Article shall be deemed to authorize or require medical examination, immunization or treatment for those who object thereto on religious grounds, except where such is necessary for the protection of the health or safety of others. (1973, c. 295, s. 5; 1991 (Reg. Sess., 1992), c. 1021, s. 2.) NCGS § 95-130 (12).

Guide to Selection and Tasks Requiring Personal Protective Equipment

Task/Activity	Gloves	Mask	Protective Eyewear	Gown	Pocket Ventilator or Equivalent device
Bleeding control with spurting blood	X	X	X	X	
Bleeding control with minimal bleeding	X				
Emergency childbirth	X	X	X	X	
Blood drawing	X				
Starting an IV	X				
Inserting an ET tube	X	X	X		
Inserting an oral airway	X	X	X		
Oral or nasal suctioning	X	X	X		
Taking vital signs					
Giving an injection	X				
Handling or cleaning contaminated instruments	X				
Ventilation or assisted ventilation	X				X

Hepatitis B Vaccine Information Sheet
Consent or Declination

The City of Greenville has made the Hepatitis B vaccine available free of charge to employees who perform duties that have been classified as Category I or Category II, in accordance with the Bloodborne Pathogen Exposure Control Plan. As a service to employees for purposes of information and training we offer the following information, so that an informed decision can be made, prior to accepting or declining the vaccination series.

Hepatitis B virus causes inflammation of the liver. Symptoms sometimes include symptoms such as nausea, fatigue, jaundice (yellow skin), loss of appetite, and weakness. A small percentage of persons who contract Hepatitis B will develop chronic hepatitis. Chronic hepatitis can be fatal, but more commonly leads to cirrhosis of the liver. Once you are infected with the virus, it may be 2-5 months before you see any symptoms

Hepatitis B virus is found in blood and many other body fluids. The infection is spread through sexual contact or by blood or other fluids of an infected person coming into contact with blood or mucous membranes (eyes and mouth) of another person.

Hepatitis B vaccine is recommended for all persons who are at increased risk of infection with Hepatitis B virus. Occupationally, health care workers are at high risk as well as Police, Fire, Rescue personnel and others as identified in the Exposure Control Plan. The vaccine does not contain human serum and will not transmit any infection. If you receive the vaccine, you will not develop Hepatitis, AIDS or any other viral illness because to took the vaccine. Studies have shown a 90% effective rate after completion of the entire vaccination series. Boosters are not normally required.

There are very few side effects associated with the vaccine series, but the following are mentioned for information purposes: soreness and redness at the injection site, flu-like symptoms and low grade fever, If you are pregnant, we recommend discussing all vaccines and medications with your health provider. Because it is unnecessary, the vaccine is not recommended for persons with immunity to Hepatitis B.

After signing the consent below, you will be scheduled to receive the immunization in three doses (dose 1 - now, dose 2 - one month from now, dose 3 -five months from now). After the immunization series is completed, you will have a blood test for antibody to Hepatitis B virus. This blood test and the immunization injections are done without charge to you. If the blood test indicates you are not yet immune, additional doses may be given. If for some reason you leave employment with the City of Greenville prior to completion of the series, it is recommended that you complete the vaccine elsewhere.

Hepatitis B Vaccine Consent Form

I have read the above statements about Hepatitis B virus vaccine and have had an opportunity to ask questions. I understand that my current duties as an employee with the City of Greenville may put me at risk of contacting Hepatitis B virus and therefore, it would benefit me to participate in the vaccination series.

I consent to receive injections of Hepatitis B virus vaccine and to have blood drawn following the series.

NAME OF EMPLOYEE (PRINTED):_____

SIGNATURE OF EMPLOYEE: _____

DATE SIGNED: _____ JOB TITLE: _____

Hepatitis B Vaccine Declination Form
(Mandatory for all Personnel who Decline Vaccination)

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

NAME OF EMPLOYEE (PRINTED):_____

SIGNATURE OF EMPLOYEE: _____

DATE SIGNED: _____ JOB TITLE: _____

CONFIDENTIAL

Communicable Disease Health History and Immunization Record

Instructions: There will be times when an employee is exposed to blood or other body fluids and the most appropriate post exposure follow-up will be dependant upon their personal health history, allergies and immunizations. This record will become part of your Infection Control File. There are three sections to this form. All employees must complete **SECTION 1**. Only one of the two remaining sections must be completed.

Do not complete both sections **2** and **3**.

SECTION 1		
Last Name:	First Name:	Middle Initial:
Date of Birth:	SSN:	Sex: M F

SECTION 2

I understand that the purpose of this disclosure and authorization relates to my occupational exposure to blood and other potentially infectious materials that may put me at risk of acquiring infection. I also understand that the City of Greenville is responsible for offering and providing post exposure follow-up care to myself for valid occupational exposures according to OSHA Rule, CFR 29, 1910.1030 and the Comprehensive Aids Resources Act of 1990. I realize that the Designated Infection Control Officer(s) will be best prepared to plan and ensure the most appropriate follow-up care by having the information below. I provide this information freely and voluntarily solely for the purposes expressed herein.

Signature: Date:

COMMUNICABLE DISEASE HISTORY

DISEASE	YES	NO	UNKNOWN	DATE OF ILLNESS
Red Measles (Rubeola)				
German Measles (Rubella)				
Mumps				
Chicken Pox				
Hepatitis A				
Hepatitis B				
Hepatitis C				
Tuberculosis				
Meningitis				
Malaria				
HIV Infection				
Syphilis				
West Nile Virus				

ALLERGIES

Medications:

Other:

Latex: Y N

IMMUNIZATION RECORD

VACCINE	DATE(S)
Hepatitis A (HepA)	
Hepatitis A-B (HepA-HepB)	
Hepatitis B	
Hepatitis B Titer Result:	
Measles, Mumps, Rubella (MMR)	
Tetanus, Diphtheria (Td)	
Chicken Pox (VAR)	
Influenza (FLU)	
Pneumococcal (PPV)	
Tuberculosis (PPD) Result:	

SECTION 3
I understand that the purpose of the Section 2 disclosure and authorization relates to my occupational exposure to blood and other potentially infectious materials that may put me at risk of acquiring infection. I also understand that the City of Greenville is responsible for offering and providing post exposure follow-up care to myself for valid occupational exposures according to OSHA Rule, CFR 29, 1910.1030 and the Comprehensive Aids Resources Act of 1990. I realize that the Designated Infection Control Officer(s) will NOT be best prepared to plan and ensure the most appropriate follow-up care by declining to provide the Section 2 information above. I have been given the opportunity to provide this information freely and voluntarily solely for the purposes expressed herein and hereby decline. Signature: Date:

Infection Control Policy
Pitt County Memorial Hospital

Emergency Response Employee (ERE) and Good Samaritan: Management of Exposure to Blood or Body Fluids

POLICY NUMBER: G7

Effective Date: 10/95 Review Date: 05/01

Approved by:

_____ _____
Medical Director, Infection Control Director, Infection Control

Purpose

To provide guidelines for investigation and notification of Emergency Response Employees' (ERE) or Good Samaritan's exposure to blood or body fluids. This policy covers only exposure to bloodborne pathogens. Routine notification of ERE facility's Designated Officer (DO), or the Good Samaritan's personal physician, with respect to airborne or uncommon or rare infectious diseases will be the responsibility of PCMH's Infection Control Department. Pitt County Memorial Hospital does not assume responsibility for exposures in ERE or Good Samaritans, but will make every reasonable effort to initiate appropriate notification of such personnel who are potentially exposed to communicable disease and in accordance with the Ryan White Act 42 USC 300FF-82 et sig ("the Act"). All reasonable efforts will be made to inform all EREs of subsequent contagious infectious diagnoses in patients they transport to PCMH.

Definition of Terms

Emergency Response Employee (ERE): Fire fighters, law enforcement officers, EMS personnel, technicians, and all interfacility transport personnel who are not employed by PCMH, and who are "on duty" at the time of exposure. Off duty personnel will be covered under the Good Samaritan provision.

Designated Officer of Emergency Response Personnel: Persons identified by Emergency Service organizations who are designated to provide notice of an ERE's exposure to bloodborne pathogens. Each agency will provide a list to the PCMH Infection Control Department of persons (including phone numbers and mailing addresses) identified to provide such notice.

Good Samaritan: Person is rendering aid and is not covered by Ryan White Act or OSHA's Bloodborne Pathogens Standard. May include general non-employed public, "off duty" employees**,** and private physicians.

Exposure: An exposure to blood or body fluids only. Exposures to airborne or rare or uncommon diseases will be the responsibility of the PCMH Infection Control Department to notify the ERE DO. A bloodborne exposure (HIV, Hepatitis B, Hepatitis C) to ERE personnel may include:

A puncture or a cut from any sharp object previously contaminated with blood/body fluids. (Example: accidental needle stick, scalpel cut, suture needle stick, test-tube glass sliver cut, or cuts from vehicle wreckage where blood contamination might exist.)

Contamination with blood/body fluid on any exposed area of the body with broken or nonintact skin. (Example: Blood contamination of hands or arms where cuts, nicks, open wounds, severe chapping, or open hangnails exist, and splash onto the face where open acne lesions or cold sores exist.)

Contamination with blood/body fluids to any mucous membrane surface. (Example: A splash or splatter which introduces blood onto the mucous membrane lining of the eye, nose, or mouth,) **NOTE: Contamination of unbroken intact skin by blood or body fluids does NOT constitute an exposure, as no evidence of percutaneous transmission of any virus has been demonstrated. A human bite which draws blood may be considered an exposure for Hepatitis**.

Source Patient: Patient that is the source of the blood or body fluid exposure to the ERE. Blood or body fluids from the source patient must come in contact with ERE personnel in one of the routes listed under the definitions of an Exposure (above) to be considered a valid source patient.

Procedures

For Emergency Response Employees who Present at PCMH
Emergency Response Employee (ERE) will:

1. Complete the **ERE Blood/Body Fluid Exposure Report Form** (see **Appendix A**). Exposure reports for ERE will be maintained by the Emergency Department. Blank exposure forms will be available in the red book in the Emergency Room Department B Side (next to the Radio Room). This book will be clearly marked Emergency Response Employee Exposures.
2. Report to the Emergency Department for evaluation and admission.
3. Ensure that ED physician signs ERE Blood/Body Fluid Exposure Report Form.
4. Fax completed ERE Blood/Body Fluid Exposure Report Form to ERE's Designated (DO) officer at parent facility.
5. Report exposure to ERE DO via phone call to ensure ERE DO's receipt of completed ERE Blood/Body Fluid Exposure Report Form.

Emergency Department Attending Physician will:

1. Review ERE's completed ERE Blood/Body Fluid Exposure Report Form for completeness and sign in space provided and return to ERE.
2. Verify that the description of the ERE's exposure constitutes a significant risk of disease transmission and review the source patient's chart to determine risk level (see **Exposure to Blood/Body Fluid Algorithm** - **Appendix C**). Medical records will be reviewed for:
    1. Results of tests diagnostic for any of the diseases covered by this law. This law does not require medical facilities to test patients for any infectious diseases, or to disclose identifying information about the patient. However, if it is determined that the ERE experienced a significant blood/body fluid exposure, ED physician may request appropriate source patient testing. Testing may include, but is not limited to, Hepatitis B, Hepatitis C, and/or HIV. All testing shall be in compliance with legal guidelines.
    2. Signs or symptoms exhibited by the source patient compatible with any of the diseases covered by the Act.
3. Complete appropriate source patient counseling and consent, and document this on source patient's chart.
4. If consent is given, draw blood to be held in the lab for appropriate source patient testing. The Medical Director of Infection Control will serve as the attending physician for source patient testing. Source patient will not be charged for source patient testing.
5. If source patient is known HIV negative or not at high risk for HIV, no further workup is needed. Discharge ERE and bill appropriate ERE employer.
6. If source patient is known HIV positive or at high risk for HIV, refer to **AIDS/HIV Post Exposure Protocol (PEP)** - see **Appendix C**.
7. Schedule a return visit to PCMH for post-test counseling of the source patient which will be performed by the Medical Director of Infection Control.

Designated Officer of Emergency Response Personnel (ERE DO) will:

1. Review completed ERE Blood/Body Fluid Exposure Report Form for completeness and sign in space provided. Ensure that exposure is valid and check in space provided.
2. Fax signed ERE Blood/Body Fluid Exposure Report Form to PCMH Infection Control Department (816-8280).

PCMH's Infection Control Department will:

1. Follow up with the ERE facility's DO by telephone within 48 hours of the receipt of a signed ERE Blood/Body Fluid Exposure Report Form.
2. Review testing on source patient.
3. In the event the source patient's identity cannot be determined, an **ERE Blood/Body Fluid Exposure Response Letter** (Appendix B) will be sent to the ERE's DO.
4. After source patient HIV, Hepatitis B and C test results have been received, complete the ERE Blood/Body Fluid Exposure Response Letter and mail to appropriate ERE DO.
5. Maintain the ERE Blood/Body Fluid Exposure Report Form and the completed ERE Blood/Body Fluid Exposure Response Letter in the Infection Control Department files.
6. Maintain the ERE Blood/Body Fluid Exposure Report Form and the completed ERE Blood/Body Fluid Exposure Response Letter in the Infection Control Department files.

"Good Samaritan" Provision:

1. In the event a "Good Samaritan" is involved in blood/body fluid exposure and the event is reported to the PCMH Infection Control Department, the "Good Samaritan" will be referred to his/her personal physician or the health department in the county the "good samaritan" resides if there is no personal physician. Evaluation and follow-up will be provided by the "Good Samaritan's" personal physician or the health department. The Medical Director of Infection Control will serve as the attending physician for source patient testing. Results of source patient testing will be communicated from the Medical Director of Infection Control to the "Good Samaritan's" personal physician. If the health department acts as designated officer for the "Good Samaritan", results of source patient testing will be communicated by Infection Control staff.
2. In the event the "Good Samaritan" presents to PCMH ED, procedures under "**Emergency Department Attending Physician** will:" should be followed. "Good Samaritan" will be admitted to the ED and billed appropriately for work-up.

3. The PCMH Occupational Health Blood Exposure Nurse may act as evaluator of the blood exposure risk and counselor for source patient testing if designated by the Medical Director of Infection Control or the attending physician.

For Emergency Response Employees who Present at Facilities Other Than PCMH:

When a call to Infection Control is received from an outside health care facility that an ERE has been exposed to blood/body fluid from a patient that has been transferred to PCMH, the **Infection Control Department will:**

1. Contact the PCMH OH Blood Exposure Nurse who will perform the risk assessment and counsel the source patient for source patient testing.
2. Obtain a physician contact from the outside agency for notification of risk assessment and source patient test results and forward this information to the PCMH OH Blood Exposure Nurse. The Medical Director of Infection Control will serve as support in decision making.
3. Notify the physician contact at the outside agency via the Medical Director of Infection Control of the risk assessment and source patient test results.

In the event the ERE presenting to the outside facility occurs when the Infection Control and Occupational Health departments are closed, **The Patient Care Coordinator will:**

1. Complete the risk assessment of the PCMH patient.
2. Notify the Patient Care coordinator at the outside agency of the risk assessment results.
3. Obtain the physician contact at the outside agency for notification of risk assessment and source patient test results. For support in decision-making, the ECU Infectious Disease Physician on-call should be consulted.
4. Forward the risk assessment and physician contact information to PCMH OH.

OH Blood Exposure Nurse will:

1. Obtain source patient testing on the next working day.
2. Notify Infection Control of the name and medical record number of the source patient and that source testing has been ordered.

Infection Control Department will:

1. Obtain source patient test results.
2. Notify the physician contact at the outside agency via the Medical Director of Infection Control of the source patient's test results.

Refer to Appendix D: Exposure to Blood/Body Fluid for ERE Presenting To Outside Facility.

APPENDIX A - EMERGENCY RESPONSE EMPLOYEE BLOOD/BODY FLUID EXPOSURE REPORT FORM

Directions: To be completed by the emergency response employee who received the blood or body fluid exposure. After completion, **present this form to the ED Attending physician for evaluation and signature**. Fax signed form to your Designated Officer (DO) (at your parent facility). ERE DO will review, sign and fax to the PCMH Infection Control Department (816-8280).

Name Of ERE:_____ Phone: Work _____Home _____

Date of Exposure: _____ Time: _____ Organization: _____
(Rescue Squad, F.D., P.D. ,etc.)

Name of Designated Officer (EMS Coordinator): _____

ERE Signature: _____

Source Patient's Name: _____ Birth Date: _____ Med Rec No: _____ Age: ____ Sex: ____

Patient's Address (if known): _____

Exact Nature of Exposure: _____

Protection Used to Avoid Exposure: ___Gloves ___Mask ___Face Shield ___CPR Barrier ___Gown ___Other

PLEASE PLACE A CHECK MARK (√) BESIDE DESCRIPTION(S) THAT APPLY TO YOUR EXPOSURE.

_____ A puncture or a cut from any sharp object previously contaminated with blood/body fluids. (Example: accidental needle stick, scalpel cut, suture needle stick, test-tube glass sliver cut, or cuts from vehicle wreckage where blood contamination might exist.)

_____ Contamination with blood/body fluid on any exposed area of the body with broken or nonintact skin. (Example: Blood contamination of hands or arms where cuts, nicks, open wounds, severe chapping, or open hangnails exist, and splash onto the face where open acne lesions or cold sores exist.)

_____ Contamination with blood/body fluids to any mucous membrane surface. (Example: A splash or splatter which introduces blood onto the mucous membrane lining of the eye, nose, or mouth.)

NOTE: Contamination of unbroken intact skin by blood or body fluids does NOT constitute an exposure, as no evidence of percutaneous transmission of any virus has been demonstrated by this method. A human bite which draws blood may be considered an exposure for Hepatitis.

ED Attending Physician:_____
(Signature)

Date: _____ Patient/Source high risk? Yes_____No_____

ERE DO: Valid exposure? Yes_____ No_____ ERE DO Signature:_____

FAX COMPLETED FORM IMMEDIATELY TO APPROPRIATE DO:

For Pitt County ERE:	Pitt County Emergency Services	Fax No. 830-6348
For Greenville ERE:	Greenville Fire and Rescue Coordinator	Fax No. 329-4374

APPENDIX B - EMERGENCY RESPONSE EMPLOYEE (ERE) BLOOD/BODY FLUID EXPOSURE RESPONSE LETTER

DATE: _____

TO: _____

_____

_____

Pitt County Memorial Hospital has received an ERE Blood/Body Fluid Exposure Form on:

_____ Date_____
Name of ERE

After careful investigation, it has been determined that:

_____ 1. According to the information provided, the ERE has had a blood/body fluid exposure to a patient transported to PCMH on_____ .
date

_____ 2. The ERE Blood/Body Fluid Exposure Form is insufficient for the following reason:
_____

_____

_____

_____ 3. Test results on the patient/source indicate source is negative and therefore is low risk for HIV, Hepatitis B and Hepatitis C disease.

_____ 4. Criteria for blood/body fluid exposure was not met.

_____ 5. The patient/source was not admitted to PCMH and blood was not available for testing.

_____ 6. Follow-up by the ERE's employing agency is indicated.

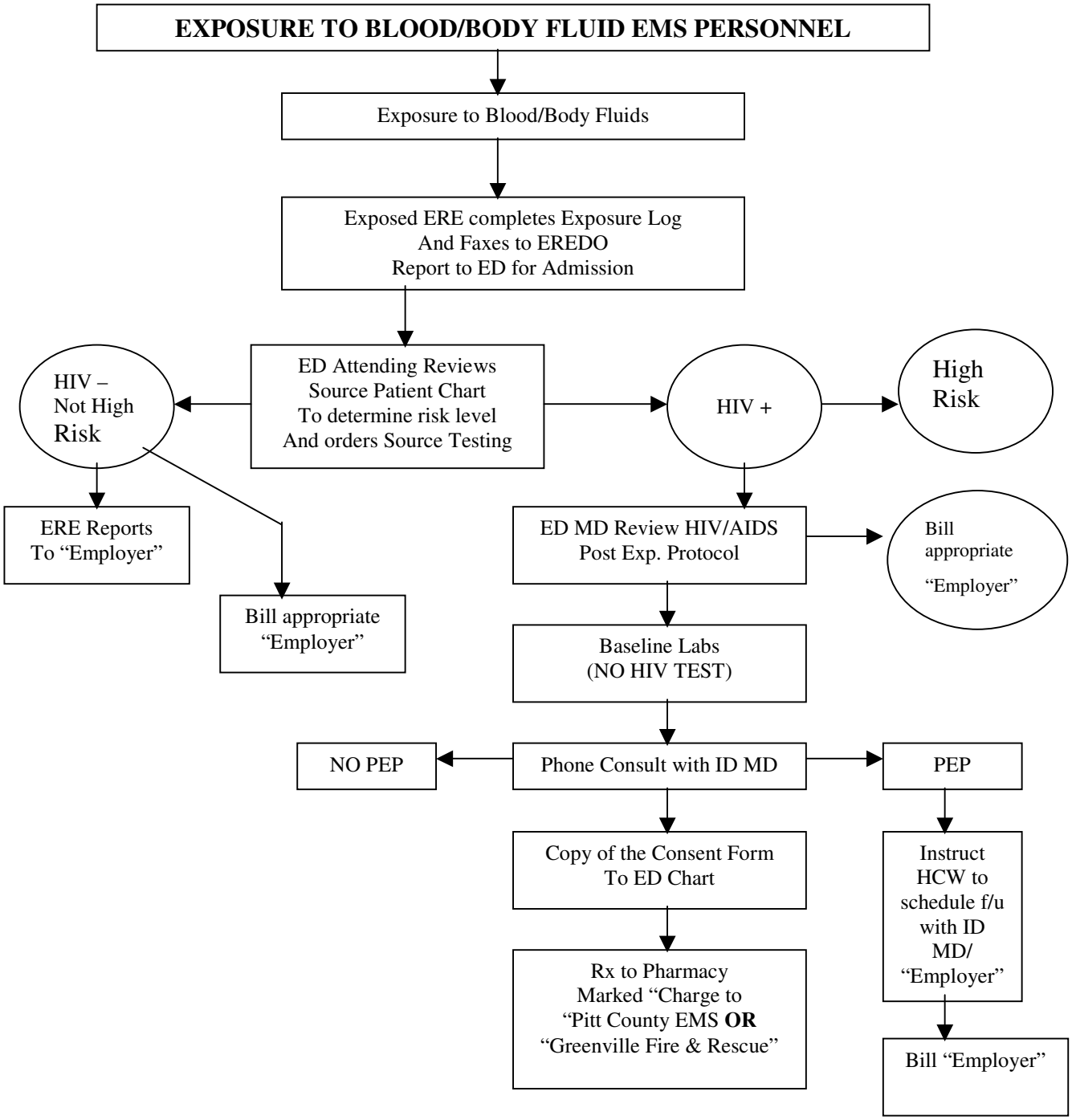
Please call for any questions regarding this matter.

Pitt County Memorial Hospital
Infection Control Department
PO Box 6028 - 2100 Stantonsburg Road
Greenville, NC 27835-6028
Tel # 252-847-4387, Fax # 252-8476-8280

Reviewed by: _____ (Infection Control Practitioner)
(Signature)

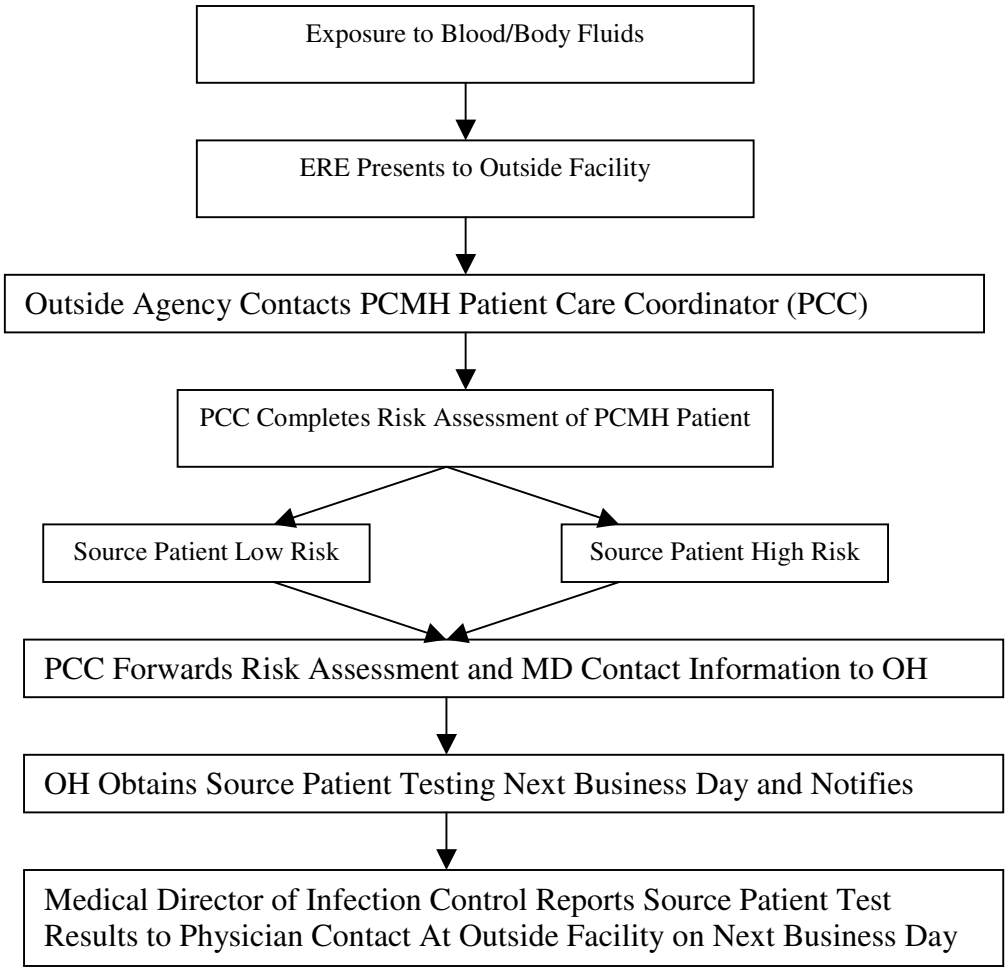
cc: Cassandra Salgado, MD

APPENDIX C - EXPOSURE TO BLOOD/BODY FLUID ALGORITHM



APPENDIX D - EXPOSURE TO BLOOD/BODY FLUID FOR ERE PRESENTING TO OUTSIDE FACILITY

ERE Exposure To Blood/Body Fluids Who Presents To Facility Other Than PCMH And Source



Post Exposure Follow Up Procedures

Experts from "Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and Recommendations for Post Exposure Prophylaxis", CDC/MMWR, Recommendations and Reports, June 29, 2001 / 50(RR11);1-42.

Not all occupational exposures will result in post exposure prophylaxis. The attending medical physician (in consultation with appropriate experts as needed) will make the determination utilizing the following factors

BOX 2. Factors to consider in assessing the need for follow-up of occupational exposures

- **Type of exposure**
  - Percutaneous injury
  - Mucous membrane exposure
  - Nonintact skin exposure
  - Bites resulting in blood exposure to either person involved
- **Type and amount of fluid/tissue**
  - Blood
  - Fluids containing blood
  - Potentially infectious fluid or tissue (semen; vaginal secretions; and cerebrospinal, synovial, pleural, peritoneal, pericardial, and amniotic fluids)
  - Direct contact with concentrated virus
- **Infectious status of source**
  - Presence of HBsAg
  - Presence of HCV antibody
  - Presence of HIV antibody
- **Susceptibility of exposed person**
  - Hepatitis B vaccine and vaccine response status
  - HBV, HCV, and HIV immune status

BOX 3. Evaluation of occupational exposure sources

Known sources

- Test known sources for HBsAg, anti-HCV, and HIV antibody
  - Direct virus assays for routine screening of source patients are **not** recommended
  - Consider using a rapid HIV-antibody test
  - If the source person is **not** infected with a bloodborne pathogen, baseline testing or further follow-up of the exposed person is **not** necessary
- For sources whose infection status remains unknown (e.g., the source person refuses testing), consider medical diagnoses, clinical symptoms, and history of risk behaviors
- Do not test discarded needles for bloodborne pathogens

Unknown sources

- For unknown sources, evaluate the likelihood of exposure to a source at high risk for infection
  - Consider likelihood of bloodborne pathogen infection among patients in the exposure setting

BOX 4. Situations for which expert* consultation for HIV postexposure prophylaxis is advised

- Delayed (i.e., later than 24–36 hours) exposure report
  - — the interval after which there is no benefit from postexposure prophylaxis (PEP) is undefined
- Unknown source (e.g., needle in sharps disposal container or laundry)
  - — decide use of PEP on a case-by-case basis
  - — consider the severity of the exposure and the epidemiologic likelihood of HIV exposure
  - — do not test needles or other sharp instruments for HIV
- Known or suspected pregnancy in the exposed person
  - — does not preclude the use of optimal PEP regimens
  - — do not deny PEP solely on the basis of pregnancy
- Resistance of the source virus to antiretroviral agents
  - — influence of drug resistance on transmission risk is unknown
  - — selection of drugs to which the source person's virus is unlikely to be resistant is recommended, if the source person's virus is known or suspected to be resistant to ≥1 of the drugs considered for the PEP regimen
  - — resistance testing of the source person's virus at the time of the exposure is not recommended
- Toxicity of the initial PEP regimen
  - — adverse symptoms, such as nausea and diarrhea are common with PEP
  - — symptoms often can be managed without changing the PEP regimen by prescribing antimotility and/or antiemetic agents
  - — modification of dose intervals (i.e., administering a lower dose of drug more frequently throughout the day, as recommended by the manufacturer), in other situations, might help alleviate symptoms

*Local experts and/or the National Clinicians' Post-Exposure Prophylaxis Hotline (PEPline [1-888-448-4911]).

For employees who have an occupational exposure to HBV virus these are the guidelines:

Management of Exposures to HBV

For percutaneous or mucosal exposures to blood, several factors must be considered when making a decision to provide prophylaxis, including the HBsAg status of the source and the hepatitis B vaccination and vaccine-response status of the exposed person. Such exposures usually involve persons for whom hepatitis B vaccination is recommended. Any blood or body fluid exposure to an unvaccinated person should lead to initiation of the hepatitis B vaccine series.

The hepatitis B vaccination status and the vaccine-response status (if known) of the exposed person should be reviewed. A summary of prophylaxis recommendations for percutaneous or mucosal exposure to blood according to the HBsAg status of the exposure source and the vaccination and vaccine-response status of the exposed person is included in this report (Table 3).

When HBIG is indicated, it should be administered as soon as possible after exposure (preferably within 24 hours). The effectiveness of HBIG when administered >7 days after exposure is unknown. When hepatitis B vaccine is indicated, it should also be administered as soon as possible (preferably within 24 hours) and can be administered simultaneously with HBIG at a separate site (vaccine should always be administered in the deltoid muscle).

For exposed persons who are in the process of being vaccinated but have not completed the vaccination series, vaccination should be completed as scheduled, and HBIG should be added as indicated (Table 3). Persons exposed to HBsAg-positive blood or body fluids who are known not to have responded to a primary vaccine series should receive a single dose of HBIG and reinitiate the hepatitis B vaccine series with the first dose of the hepatitis B vaccine as soon as possible after exposure. Alternatively, they should receive two doses of HBIG, one dose as soon as possible after exposure, and the second dose 1 month later. The option of administering one dose of HBIG and reinitiating the vaccine series is preferred for nonresponders who did not complete a second 3-dose vaccine series. For persons who previously completed a second vaccine series but failed to respond, two doses of HBIG are preferred.

TABLE 3. Recommended postexposure prophylaxis for exposure to hepatitis B virus

Vaccination and antibody response status of exposed workers*	Treatment		
	Source HBsAg† positive	Source HBsAg† negative	Source unknown or not available for testing
Unvaccinated	HBIG§ x 1 and initiate HB vaccine series¶	Initiate HB vaccine series	Initiate HB vaccine series
Previously vaccinated			
Known responder**	No treatment	No treatment	No treatment
Known nonresponder††	HBIG x 1 and initiate revaccination or HBIG x 2§§	No treatment	If known high risk source, treat as if source were HBsAg positive
Antibody response unknown	Test exposed person for anti-HBs¶ 1. If adequate,** no treatment is necessary 2. If inadequate,†† administer HBIG x 1 and vaccine booster	No treatment	Test exposed person for anti-HBs 1. If adequate,¶ no treatment is necessary 2. If inadequate,¶ administer vaccine booster and recheck titer in 1–2 months

* Persons who have previously been infected with HBV are immune to reinfection and do not require postexposure prophylaxis.

† Hepatitis B surface antigen.

§ Hepatitis B immune globulin; dose is 0.06 mL/kg intramuscularly.

¶ Hepatitis B vaccine.

** A responder is a person with adequate levels of serum antibody to HBsAg (i.e., anti-HBs ≥10 mIU/mL).

†† A nonresponder is a person with inadequate response to vaccination (i.e., serum anti-HBs < 10 mIU/mL).

§§ The option of giving one dose of HBIG and reinitiating the vaccine series is preferred for nonresponders who have not completed a second 3-dose vaccine series. For persons who previously completed a second vaccine series but failed to respond, two doses of HBIG are preferred.

¶¶ Antibody to HBsAg.

For employees who have an occupation exposure to HIV:

Follow-up of HCP Exposed to HIV

Post Exposure Testing. HCP with occupational exposure to HIV should receive follow-up counseling, post exposure testing, and medical evaluation, regardless of whether they receive PEP. HIV-antibody testing should be performed for at least 6 months post exposure (e.g., at 6 weeks, 12 weeks, and 6 months). Extended HIV follow-up (e.g., for 12 months) is recommended for HCP who become infected with HCV following exposure to a source co-infected with HIV and HCV. Whether extended follow-up is indicated in other circumstances (e.g., exposure to a source co-infected with HIV and HCV in the absence of HCV seroconversion or for exposed persons with a medical history suggesting an impaired ability to develop an antibody response to acute infection) is unclear. Although rare instances of delayed HIV seroconversion have been reported (*167,168*), the infrequency of this occurrence does not warrant adding to the anxiety level of the exposed persons by routinely extending the duration of postexposure follow-up. However, this recommendation should not preclude a decision to extend follow-up in an individual situation based on the clinical judgment of the exposed person's health-care provider. HIV testing should be performed on any exposed person who has an illness that is compatible with an acute retroviral syndrome, regardless of the interval since exposure. When HIV infection is identified, the person should be referred to a specialist knowledgeable in the area of HIV treatment and counseling for medical management.

HIV-antibody testing with EIA should be used to monitor for seroconversion. The routine use of direct virus assays (e.g., HIV p24 antigen EIA or tests for HIV RNA) to detect infection in exposed HCP generally is not recommended (*169*). The high rate of false-positive results of these tests in this setting could lead to unnecessary anxiety and/or treatment (*170,171*). Despite the ability of direct virus assays to detect HIV infection a few days earlier than EIA, the infrequency of occupational seroconversion and increased costs of these tests do not warrant their routine use in this setting.

- HIV-antibody testing should be performed for at least 6 months post exposure.
- Direct virus assays for routine follow-up of HCP are not recommended.
- HIV testing should be performed on any exposed person who has an illness compatible with an acute retroviral syndrome.

Monitoring and Management of PEP Toxicity. If PEP is used, HCP should be monitored for drug toxicity by testing at baseline and again 2 weeks after starting PEP. The scope of testing should be based on medical conditions in the exposed person and the toxicity of drugs included in the PEP regimen. Minimally, lab monitoring for toxicity should include a complete blood count and renal and hepatic function tests. Monitoring for evidence of hyperglycemia should be included for HCP whose regimens include any PI; if the exposed person is receiving IDV, monitoring for crystalluria, hematuria, hemolytic anemia, and hepatitis also should be included. If toxicity is noted, modification of the regimen should be considered after expert consultation; further diagnostic studies may be indicated.

Exposed HCP who choose to take PEP should be advised of the importance of completing the prescribed regimen. Information should be provided to HCP about potential drug interactions and the drugs that should not be taken with PEP, the side effects of the drugs that have been prescribed, measures to minimize these effects, and the methods of clinical monitoring for toxicity during the follow-up period. HCP should be advised that the evaluation of certain symptoms should not be delayed (e.g., rash, fever, back or abdominal pain, pain on urination or blood in the urine, or symptoms of hyperglycemia [increased thirst and/or frequent urination]).

HCP who fail to complete the recommended regimen often do so because of the side effects they experience (e.g., nausea and diarrhea). These symptoms often can be managed with antimotility and antiemetic agents or

other medications that target the specific symptoms without changing the regimen. In other situations, modifying the dose interval (i.e., administering a lower dose of drug more frequently throughout the day, as recommended by the manufacturer), might facilitate adherence to the regimen. Serious adverse events should be reported to FDA's MedWatch Program.

Counseling and Education. Although HIV infection following an occupational exposure occurs infrequently, the emotional effect of an exposure often is substantial (*172--174*). In addition, HCP are given seemingly conflicting information. Although HCP are told that a low risk exists for HIV transmission, a 4-week regimen of PEP might be recommended, and they are asked to commit to behavioral measures (e.g., sexual abstinence or condom use) to prevent secondary transmission, all of which influence their lives for several weeks to months (*172*). Therefore, access to persons who are knowledgeable about occupational HIV transmission and who can deal with the many concerns an HIV exposure might generate for the exposed person is an important element of post exposure management. HIV-exposed HCP should be advised to use the following measures to prevent secondary transmission during the follow-up period, especially the first 6--12 weeks after the exposure when most HIV-infected persons are expected to seroconvert: exercise sexual abstinence or use condoms to prevent sexual transmission and to avoid pregnancy; and refrain from donating blood, plasma, organs, tissue, or semen. If an exposed woman is breast feeding, she should be counseled about the risk of HIV transmission through breast milk, and discontinuation of breast feeding should be considered, especially for high-risk exposures. Additionally, NRTIs are known to pass into breast milk, as is NVP; whether this also is true for the other approved antiretroviral drugs is unknown.

The patient-care responsibilities of an exposed person do not need to be modified, based solely on an HIV exposure, to prevent transmission to patients. If HIV seroconversion is detected, the person should be evaluated according to published recommendations for infected HCP (*175*).

Exposed HCP should be advised to seek medical evaluation for any acute illness that occurs during the follow-up period. Such an illness, particularly if characterized by fever, rash, myalgia, fatigue, malaise, or lymphadenopathy, might be indicative of acute HIV infection but also might be indicative of a drug reaction or another medical condition.

For exposures for which PEP is considered appropriate, HCP should be informed that a) knowledge about the efficacy of drugs used for PEP is limited; b) experts recommend combination drug regimens because of increased potency and concerns about drug-resistant virus; c) data regarding toxicity of antiretroviral drugs in persons without HIV infection or in pregnant women are limited; d) although the short-term toxicity of antiretroviral drugs is usually limited, serious adverse events have occurred in persons taking PEP; and e) any or all drugs for PEP may be declined or stopped by the exposed person. HCP who experience HIV occupational exposures for which PEP is not recommended should be informed that the potential side effects and toxicity of taking PEP outweigh the negligible risk of transmission posed by the type of exposure.

Guidelines for counseling and educating HCP with HIV exposure include

- Exposed HCP should be advised to use precautions to prevent secondary transmission during the follow-up period.
- For exposures for which PEP is prescribed, HCP should be informed about possible drug toxicities and the need for monitoring, and possible drug interactions.

For employees who have an occupational exposure to HIV virus through a percutaneous injury, these are the guidelines:

TABLE 4. Recommended HIV postexposure prophylaxis for percutaneous injuries

	Infection status of source				
Exposure type	HIV-Positive Class 1*	HIV-Positive Class 2*	Source of unknown HIV status†	Unknown source§	HIV-Negative
Less severe¶	Recommend basic 2-drug PEP	Recommend expanded 3-drug PEP	Generally, no PEP warranted; however, consider basic 2-drug PEP** for source with HIV risk factors††	Generally, no PEP warranted; however, consider basic 2-drug PEP** in settings where exposure to HIV-infected persons is likely	No PEP warranted
More severe§§	Recommend expanded 3-drug PEP	Recommend expanded 3-drug PEP	Generally, no PEP warranted; however, consider basic 2-drug PEP** for source with HIV risk factors††	Generally, no PEP warranted; however, consider basic 2-drug PEP** in settings where exposure to HIV-infected persons is likely	No PEP warranted

* HIV-Positive, Class 1 — asymptomatic HIV infection or known low viral load (e.g., <1,500 RNA copies/mL). HIV-Positive, Class 2 — symptomatic HIV infection, AIDS, acute seroconversion, or known high viral load. If drug resistance is a concern, obtain expert consultation. Initiation of postexposure prophylaxis (PEP) should not be delayed pending expert consultation, and, because expert consultation alone cannot substitute for face-to-face counseling, resources should be available to provide immediate evaluation and follow-up care for all exposures.

† Source of unknown HIV status (e.g., deceased source person with no samples available for HIV testing).

§ Unknown source (e.g., a needle from a sharps disposal container).

¶ Less severe (e.g., solid needle and superficial injury).

** The designation "consider PEP" indicates that PEP is optional and should be based on an individualized decision between the exposed person and the treating clinician.

†† If PEP is offered and taken and the source is later determined to be HIV-negative, PEP should be discontinued.

§§ More severe (e.g., large-bore hollow needle, deep puncture, visible blood on device, or needle used in patient's artery or vein).

For employees who have an occupational exposure to HIV virus through mucous membrane exposures and non-intact skin these are the guidelines:

TABLE 5. Recommended HIV postexposure prophylaxis for mucous membrane exposures and nonintact skin* exposures

	Infection status of source				
Exposure type	HIV-Positive Class 1†	HIV-Positive Class 2†	Source of unknown HIV status§	Unknown source¶	HIV-Negative
Small volume**	Consider basic 2-drug PEP††	Recommend basic 2-drug PEP	Generally, no PEP warranted; however, consider basic 2-drug PEP†† for source with HIV risk factors§§	Generally, no PEP warranted; however, consider basic 2-drug PEP†† in settings where exposure to HIV-infected persons is likely	No PEP warranted
Large volume¶¶	Recommend basic 2-drug PEP	Recommend expanded 3-drug PEP	Generally, no PEP warranted; however, consider basic 2-drug PEP†† for source with HIV risk factors§§	Generally, no PEP warranted; however, consider basic 2-drug PEP†† in settings where exposure to HIV-infected persons is likely	No PEP warranted

* For skin exposures, follow-up is indicated only if there is evidence of compromised skin integrity (e.g., dermatitis, abrasion, or open wound).

† HIV-Positive, Class 1 — asymptomatic HIV infection or known low viral load (e.g., <1,500 RNA copies/mL). HIV-Positive, Class 2 — symptomatic HIV infection, AIDS, acute seroconversion, or known high viral load. If drug resistance is a concern, obtain expert consultation. Initiation of postexposure prophylaxis (PEP) should not be delayed pending expert consultation, and, because expert consultation alone cannot substitute for face-to-face counseling, resources should be available to provide immediate evaluation and follow-up care for all exposures.

§ Source of unknown HIV status (e.g., deceased source person with no samples available for HIV testing).

¶ Unknown source (e.g., splash from inappropriately disposed blood).

** Small volume (i.e., a few drops).

†† The designation, "consider PEP," indicates that PEP is optional and should be based on an individualized decision between the exposed person and the treating clinician.

§§ If PEP is offered and taken and the source is later determined to be HIV-negative, PEP should be discontinued.

¶¶ Large volume (i.e., major blood splash).

For employees who have an occupational exposure to HCV virus these are the guidelines:

Management of Exposures to HCV

Individual institutions should establish policies and procedures for testing HCP for HCV after percutaneous or mucosal exposures to blood and ensure that all personnel are familiar with these policies and procedures. The following are recommendations for follow-up of occupational HCV exposures:

- For the source, perform testing for anti-HCV.
- For the person exposed to an HCV-positive source
- --- perform baseline testing for anti-HCV and ALT activity; and
- --- perform follow-up testing (e.g., at 4--6 months) for anti-HCV and ALT activity (if earlier diagnosis of HCV infection is desired, testing for HCV RNA may be performed at 4--6 weeks).
- Confirm all anti-HCV results reported positive by enzyme immunoassay using supplemental anti-HCV testing (e.g., recombinant immunoblot assay [RIBA™]) (*13*).

Health-care professionals who provide care to persons exposed to HCV in the occupational setting should be knowledgeable regarding the risk for HCV infection and appropriate counseling, testing, and medical follow-up.

IG and antiviral agents are not recommended for PEP after exposure to HCV-positive blood. In addition, no guidelines exist for administration of therapy during the acute phase of HCV infection. However, limited data indicate that antiviral therapy might be beneficial when started early in the course of HCV infection. When HCV infection is identified early, the person should be referred for medical management to a specialist knowledgeable in this area.

Attachment 5

Worker's Compensation Incident Report

Injury and Illness Initial Accident Form

Employee Name:_____Department:_____Division:_____

Time Employee Began Work_____AM/PM_____ Date of Injury or Onset of Illness_____

Time of Incident: _____AM/PM_____ Location Where Incident Occurred: _____

_____

What was employee doing just before incident occurred? (Describe the activity, including tools or equipment the employee was using, be specific. Examples: "climbing a ladder while carrying light fixture" or "spraying chemicals from a sprayer")_____

_____

What happened? (Examples: "when ladder slipped on wet floor, employee fell 10 feet"; or "employee was sprayed with chlorine when gasket broke during replacement") _____

_____

What was the injury or illness? (Examples: "strained back"; "irritation to right eye; or "carpal tunnel syndrome right hand") _____

What object or substance directly harmed the employee? (Examples: "concrete floor"; "chemicals from the sprayer"; or "tree branch") _____

_____

Witnesses to incident _____

Was first aid provided? _____ By Whom _____

Was employee treated in an emergency room? _____ Was employee hospitalized overnight as in-patient? _____

_____

Date _____ Signature _____

Injured Employee

Signature _____

Supervisor in Charge

Revised 2/6/02
#118609

Attachment 6

Infectious Disease/Blood/Body Fluid Exposure Form
City of Greenville

Employee's Name: _____ Date of Report / /

Employee's SSN: _____ Home Phone:_____ ACR #:_____

Source Patient:	Sex:	Age:
Suspected or confirmed disease:		
Date of exposure: / /	Time of exposure:	
Type if Incident: (Auto Accident, Trauma, Etc.)		

Were you exposed to: (I.E. direct contact)

BLOOD _____ TEARS _____ FECES _____ URINE _____ SALIVA_____ VOMITUS____ SPUTUM _____
SWEAT _____ OTHER _____ IDENTIFY _____

What parts of your body were exposed? Be specific: _____

_____

How did the exposure occur? Be specific (if applicable, describe procedure being performed) : _____

_____

If sharp device involved, list type and brand and how and when in the course of handling the device the exposure occurred: _____

_____

Were you treated at the hospital? _____ YES _____NO

By whom:_____

Date of treatment: / /	Time:

Employee's Signature:_____ Date: / /

Supervisor's Signature: _____ Date: / /

Designated officer: _____ Date: / /

Attachment 7

CITY OF GREENVILLE: **AUTHORIZATION FOR RELEASE, USE AND DISCLOSURE OF PROTECTED MEDICAL INFORMATION**

I, _____, an employee of the City of Greenville, being over the age of 18 years, and not under any disability that would prevent me from making this authorization, do hereby consent to the release of information from my medical records and further consent to my employer's discussions with my healthcare provider relating to my condition and work.

Initial as applicable:

_____ Family Medical Leave Act (FMLA) _____Workers Compensation (WC)

_____ American Disability Act (ADA) _____ OSHA Bloodborne Pathogens (OSHA BBP)

I further authorize this information to be released to my employer, City of Greenville, and not to anyone else unless I provide specific written authorization. This authorization includes my supervisor, **designated officer** (OSHA BBP only), department head, the Human Resources Department, the City Attorney's Office, City Manager, and any medical agents of my employer and insurance carriers.

My authorization relates to the specifically named healthcare provider in the blanks provided below. Any release by any other healthcare provider will require a separate authorization in writing.

Name, Address and telephone number of healthcare provider:

_____

_____

_____

The employee shall receive a Healthcare Professional's Written Opinion within 15 days of the completion of the evaluation. (OSHA BBP only)

This authorization includes the medical records maintained by the identified healthcare provider for the following described condition(s): _____

_____

_____.

1910.130(f)(5)(ii) OSHA BBP only:

1. **The hepatitis B vaccination is _____/ is not _____ indicated, and the employee has _____, has not _____ received the vaccination.**

2. **The employee has been informed of the results of the evaluation and told about any medical conditions resulting from exposure to blood or OPIMs requiring further evaluation or treatment.**

The purpose of this disclosure and authorization relates to work issues including the ability to perform the essential functions of my job if a claimed disability is involved, my fitness for duty, and other specific requirements relating to my ability to continue my employment or the capacity in which I can perform my duties. I provide this release freely and voluntarily for the purposes expressed herein, including a review by my healthcare provider of my job description and to provide my employer a written opinion concerning the purposes expressly stated above.

I understand that I may revoke this authorization. I further understand that I must present the written revocation to my department head naming the specific health care provider to whom the authorization was provided and the date of the authorization. I understand that any disclosures made by or to my healthcare provider and/or employer in reliance of my authorization does not violate my federal or state medical privacy rights, even where the disclosure is made after the date of revocation but prior to receipt of the notification by both my healthcare provider and my employer. I understand that I also must provide written revocation notification to my healthcare provider. I understand that once information is disclosed pursuant to this signed authorization the federal health privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information and therefore, may not prohibit the recipient from redisclosing it; however, state laws may prohibit such redisclosures. If such disclosures involve mental health or developmental disabilities or substance abuse treatment information, the recipient must be informed that redisclosure is prohibited.

Unless sooner revoked by me in writing, this release shall expire one year from the date of this authorization.

Signature of employee:_____.

Printed name of employee: _____.

Date of authorization: _____.

Bloodborne Pathogens Training Record

Date of Training:

Instructors name(s): _____
_____

Instructor(s) Qualifications: _____
_____

Subjects Covered

1. Location of a copy of the regulatory text of 29 CFR 1910.1030, OSHA's Bloodborne Pathogen Standard.

2. The City of Greenville's Bloodborne Pathogen Exposure Control Plan and the means by which the employee can obtain a copy of the written plan;

3. Epidemiology and symptoms of bloodborne diseases

4. The modes of transmission of bloodborne pathogens .

5. An explanation of Greenville Fire / Rescue Department exposure control plan

6. The appropriate methods for recognizing tasks and other activities that may involve exposure to blood and other infectious materials.

7. The use and limitations of practices that will prevent or reduce exposure including appropriate engineering controls, work practices, and personal protective equipment.

8. The basis of selection of personal protective equipment.

9. The types, proper use, location, removal, handling, decontamination and/or disposal of personal protective equipment;

10. The hepatitis B vaccine, including information on its efficacy, safety, method of administration and the benefits of being vaccinated, and that the vaccine and vaccination will be offered free of charge;

11. The appropriate actions to take and persons to contact in an emergency involving blood or other potential infectious materials.

12. The procedure to follow if an exposure incident occurs, including the method of reporting the incident and the medical follow-up that will be made available. Also information on the medical counseling that will be provided for exposed individuals

13. Signs, labeling, and color-coding used in conjunction with medical/infectious waste or

contaminated items.

Attendees

Name	Job Title

Sharps Injury Log
City of Greenville, NC
Year _____

Date	Case/Report No.	Type of device (e.g., syringe, suture needle)	Brand name of device	Work area where injury occurred (e.g., ambulance enroute, accident/event scene)	Brief description of how the incident occurred [i.e., procedure being done, action being performed (disposal, injection, etc), body part injured]

Signature of person certifying log: _____ Date: _____

Title of person certifying log: _____

29 CFR 1910.1030, OSHA's Bloodborne Pathogens Standard, in paragraph (h)(5), requires an employer to establish and maintain a Sharps Injury Log for recording all percutaneous injuries in a facility occurring from contaminated sharps. The purpose of the Log is to aid in the evaluation of devices being used in healthcare and other facilities and to identify problem devices or procedures requiring additional attention or review. This log must be kept in addition to the injury and illness log required by 29 CFR 1904. The Sharps Injury Log should include all sharps injuries occurring in a calendar year. The log must be retained for five years following the end of the year to which it relates. The Log must be kept in a manner that preserves the confidentiality of the affected employee.

Disease Information For Emergency Response Personnel

Disease/Infection	Mode of Transmission	Vaccine Available	Signs and Symptoms
AIDS/HIV (Human Immunodeficiency Virus)	Needlestick, blood splash into mucous membranes,	NO	Fever, night sweats, weight loss, cough
Chickenpox (Herpes Zoster)	Respiratory secretions and contact with moist vesicles	YES	Fever, Rash, cutaneous vesicles (blisters)
Diarrhea: Campylobacter Cryptosporidium Giardia Salmonella Viral Yersinia	Fecal/Oral	NO	Loose watery stools
German Measles (Rubella)	Respiratory droplets and direct contact with respiratory secretions	YES	Fever, rash
Hepatitis A (Infectious Hepatitis)	Fecal/Oral	YES	Fever, loss of appetite, jaundice, fatigue
Hepatitis B (Serum Hepatitis)	Needlestick, blood splash into mucous membranes (e.g., eyes, mouth), or blood contact with open wound	YES	Fever, fatigue, loss of appetite, nausea, headache, jaundice
Hepatitis C	Same as Hepatitis B	NO	Same as Hepatitis B
Hepatitis D	Same as Hepatitis B, dependent on HBV (past or present) to cause infection	NO	A complication of HBV infection and can increase the severity of HBV infection
Herpes Simplex (Cold Sores)	Contact of mucous membranes with moist lesions. Fingers are at particular risk for becoming infected. (Herpetic Whitlow)	NO	Skin lesions located around the mouth area
Influenza	Airborne	YES	Fever, loss of appetite, fatigue, headache, nausea
Lice (Head, Body, Pubic)	Close head to head contact. Both body and pubic lice require intimate contact (usually sexual) or sharing of clothing	NO	Severe itching and scratching, often with secondary infection. Scalp and hairy portions of body may be affected. Eggs of head lice (nits) attach to hairs as small, round, gray lumps
Measles (Rubeola)	Respiratory droplets and contact with nasal or throat secretions. Highly communicable	YES	Fever, rash, bronchitis
Meningitis/Meningococcal Influenza(usually seen in young children) Viral Meningitis	Direct contact with respiratory secretions Same Fecal/oral	NO NO YES	Fever, sever headache, stiff neck, sore throat Same Same
Mononucleosis	Direct contact with respiratory secretions or saliva, such as with mouth-to-mouth resuscitation	NO	Fever, sore throat, fatigue
Mumps (Infections Parotitis)	Respiratory droplets and direct contact with saliva	YES	Fever, swelling of salivary glands (parotid)
Salmonellosis	Foodborne	NO	Sudden onset of fever, abdominal pain, diarrhea, nausea, and frequent vomiting
Scabies	Close body contact	NO	Itching, tiny linear burrows or “tracks”, vesicules, particularly around finger, wrists, elbows and skin folds
Syphilis	Primarily sexual contact; rarely through blood transfusion	NO	Genital and cutaneous lesions, nerve degeneration (late)
Tuberculosis, Pulmonary	Airborne	NO	Fever, night sweats, weight loss, cough
Whooping Cough	Airborne, direct contact with oral secretions	YES	Violent cough at night, whooping sound when cough subsides

Sharps Containers

Safety Feature Evaluation Form

Date: _____Department:_____Occupation:_____

Product Evaluated: _____ Number of times used: _____

Please circle the most appropriate answer for each question. A rating of one (1) indicates the highest level of agreement with the statement, five (5) the lowest. Not applicable (N/A) may be used if the question does not apply to this product.

	agree.....disagree					
1. The container's shape, its markings, or its color, imply danger.	1	2	3	4	5	N/A
2. The implied warning of danger can be seen from the angle at which people commonly view it. (Don't forget about very short people, people in wheel chairs, children, etc.)	1	2	3	4	5	N/A
3. The implied warning can be universally understood by visitors, children, and patients.	1	2	3	4	5	N/A
4. The container's purpose is self-explanatory and easily understood by a healthcare worker who may be pressed for time or unfamiliar with the hospital setting.	1	2	3	4	5	N/A
5. The container can accept sharps from any direction desired.	1	2	3	4	5	N/A
6. The container can accept all sizes and shapes of sharps.	1	2	3	4	5	N/A
7. The container allows single handed operation. (Only the hand holding the sharp should be near the container opening.)	1	2	3	4	5	N/A
8. It is difficult to reach in and remove a sharp.	1	2	3	4	5	N/A
9. Sharps can go into the container without getting caught on the opening.	1	2	3	4	5	N/A
10. Sharps can go into the container without getting caught on any molded shapes in the interior.	1	2	3	4	5	N/A
11. The container is puncture resistant.	1	2	3	4	5	N/A
12. When the container is dropped or turned upside down (even before it is permanently closed) sharps stay inside.	1	2	3	4	5	N/A
13. The user can determine easily, from various viewing angles, when the container is full.	1	2	3	4	5	N/A
14. When the container is to be used free-standing (no mounting bracket), it is stable and unlikely to tip over.	1	2	3	4	5	N/A
15. It is safe to close the container. (Sharps should not protrude into the path of hands attempting to close the container.)	1	2	3	4	5	N/A
16. The container closes securely. (e.g. if the closure requires glue, it may not work if the surfaces are soiled or wet.)	1	2	3	4	5	N/A
17. The product has handles which allow you to safely transport a full container.	1	2	3	4	5	N/A
18. The product does not require extensive training to operate correctly.	1	2	3	4	5	N/A

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Disposable Eye Protection

Safety Feature Evaluation Form

Date: _____Department:_____Occupation:_____

Product Evaluated: _____ Number of times used: _____

Please circle the most appropriate answer for each question. A rating of one (1) indicates the highest level of agreement with the statement, five (5) the lowest. Not applicable (N/A) may be used if the question does not apply to this product.

	agree.....disagree					
1. The product allows you to have it with you, or easily accessible to you at all times (fits in pocket, etc.).	1	2	3	4	5	N/A
2. The product does not fog up.	1	2	3	4	5	N/A
3. The product works well for a wide variety of head sizes.	1	2	3	4	5	N/A
4. The product is light weight.	1	2	3	4	5	N/A
5. The product is comfortable to wear for extended periods of time.	1	2	3	4	5	N/A
6. The product does not distort vision.	1	2	3	4	5	N/A
7. The product is shatter proof.	1	2	3	4	5	N/A
8. The product offers splatter protection from all angles.	1	2	3	4	5	N/A
9. The product can be used while wearing prescription glasses or can accommodate prescription lenses.	1	2	3	4	5	N/A
10. The product is easily disposable.	1	2	3	4	5	N/A

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I.V. Access Devices

Safety Feature Evaluation Form

Date: _____ Department: _____ Occupation: _____

Product Evaluated: _____ Number of times used: _____

Please circle the most appropriate answer for each question. A rating of one (1) indicates the highest level of agreement with the statement, five (5) the lowest. Not applicable (N/A) may be used if the question does not apply to this product.

	agree.....disagree					
1. The safety feature can be activated using a one-handed technique.	1	2	3	4	5	N/A
2. The safety feature does not interfere with normal use of this product.	1	2	3	4	5	N/A
3. Use of this product requires you to use the safety feature.	1	2	3	4	5	N/A
4. This device does not require more time to use than a non-safety device.	1	2	3	4	5	N/A
5. The safety feature works well with a wide variety of hand sizes.	1	2	3	4	5	N/A
6. The device allows for rapid visualization of flashback in the catheter or chamber.	1	2	3	4	5	N/A
7. Use of this product does not increase the number of sticks to the patient.	1	2	3	4	5	N/A
8. The product stops the flow of blood after the needle is removed from the catheter (or after the butterfly is inserted) and just prior to line connections or hep-lock capping.	1	2	3	4	5	N/A
9. A clear and unmistakable change (either audible or visible) occurs when the safety feature is activated.	1	2	3	4	5	N/A
10. The safety feature operates reliably.	1	2	3	4	5	N/A
11. The exposed sharp is blunted or covered after use and prior to disposal.	1	2	3	4	5	N/A
12. The product does not need extensive training to be operated correctly.	1	2	3	4	5	N/A

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Vacuum Tube Collection Systems

Safety Feature Evaluation Form

Date: _____ Department: _____Occupation:_____

Product Evaluated: _____ Number of times used: _____

Please circle the most appropriate answer for each question. A rating of one (1) indicates the highest level of agreement with the statement, five (5) the lowest. Not applicable (N/A) may be used if the question does not apply to this product.

---

	agree.....disagree					
1. The safety feature can be activated using a one-handed technique.	1	2	3	4	5	N/A
2. The safety feature does not interfere with normal use of this product.	1	2	3	4	5	N/A
3. Use of this product requires you to use the safety feature.	1	2	3	4	5	N/A
4. This product does not require more time to use than a non-safety device.	1	2	3	4	5	N/A
5. The safety feature works well with a wide variety of hand sizes.	1	2	3	4	5	N/A
6. The safety feature works with a butterfly.	1	2	3	4	5	N/A
7. A clear and unmistakable change (either audible or visible) occurs when the safety feature is activated.	1	2	3	4	5	N/A
8. The safety feature operates reliably.	1	2	3	4	5	N/A
9. The exposed sharp is blunted or covered after use and prior to disposal.	1	2	3	4	5	N/A
10. The inner vacuum tube needle (rubber sleeved needle) does not present a danger of exposure.	1	2	3	4	5	N/A
11. The product does not need extensive training to be operated correctly.	1	2	3	4	5	N/A

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Safety Feature Evaluation Form

Safety Syringes

Date:_____ Department:_____ Occupation:_____

Product Evaluated:_____ Number of times used:_____

Please circle the most appropriate answer for each question. A rating of one (1) indicates the highest level of agreement with the statement, five (5) the lowest. Not applicable (N/A) may be used if the question does not apply to this product.

	agree.....disagree					
1. The safety feature can be activated using a one-handed technique.	1	2	3	4	5	N/A
2. The safety feature does not obstruct vision of the tip of the sharp.	1	2	3	4	5	N/A
3. Use of this product requires you to use the safety feature.	1	2	3	4	5	N/A
4. This product does not require more time to use than a non-safety device.	1	2	3	4	5	N/A
5. The safety feature works well with a variety of hand sizes.	1	2	3	4	5	N/A
6. The device is easy to handle while wearing gloves.	1	2	3	4	5	N/A
7. This device does not interfere with those that do not require a needle.	1	2	3	4	5	N/A
8. This device offers at least as good a view of any aspirated fluid as a standard syringe.	1	2	3	4	5	N/A
9. This device will work with required syringe sizes.	1	2	3	4	5	N/A
10. The device provides a better alternative to traditional recapping.	1	2	3	4	5	N/A
11. There is a clear and unmistakable change (either audible or visible) that occurs when the safety feature is activated.	1	2	3	4	5	N/A
12. The safety feature operates reliably.	1	2	3	4	5	N/A
13. The exposed sharp is permanently blunted or covered after use and prior to disposal.	1	2	3	4	5	N/A
14. This device is no more difficult to process after use than non- safety devices.	1	2	3	4	5	N/A
15. The user does not need extensive training for correct operation.	1	2	3	4	5	N/A
16. The design of the device suggests proper use.	1	2	3	4	5	N/A
17. It is not easy to skip a crucial step in proper use of the device.	1	2	3	4	5	N/A

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Attachment 12-A

FIRE/RESCUE STATION COMPLIANCE MONITOR

DATE: **STATION:** **SUPERVISOR:**

YES	NO	CRITERIA	OBSERVATIONS
		1. Station area is clean and orderly.	
		2. Kitchen and dining area is clean and orderly.	
		3. All trash is in an approved container.	
		4. Bathrooms are clean and orderly.	
		5. Hand washing solution is available at all sinks.	
		6. Hand washing containers are full at all sinks **AND** in all EMS units and QRV's.	
		7. Personal Protective Equipment (gloves, masks, eye protection, etc.) is readily available in the station.	
		8. Area for cleaning contaminated equipment is clearly identified.	
		9. All employees confirm that contaminated linen/clothes are to be or have been bagged and labeled as BIOHAZARD.	
		10. Medical supplies are stored in a clean area.	
		11. All medical supplies, equipment, cleaning solutions, etc. are pre-expiration date both in the stations and on vehicles.	
		12. Gloves are used for cleaning all surfaces and equipment.	
		13. Surface cleaning agents are readily available.	
		14. Surface cleaning agents are dated and mixed according to manufacturer's recommendations.	
		15. Potentially contaminated work surfaces are cleaned daily at the beginning of each shift.	
		16. Potentially contaminated work surfaces are cleaned after each use.	
		17. Chemicals and all other regulated wastes are disposed of according to EPA regulations.	
		18. Needle disposal containers are located in all EMS units and QRV's **AND** are less than ¾ full.	
		19. All employees confirm that all exposures are to be immediately reported to their shift's Designated Infection Control Officer.	
		20. Infectious waste containers are in all EMS units.	
		21. Any exposure incidents from the past 3 weeks were reviewed and discussed. **N/A:**	
		22. A copy of the Exposure Control Plan is in the Station.	
		23. A copy of the Exposure Control Plan is in each EMS unit and QRV.	
		24. Hands are washed in non-food prep or storage areas after all calls, vehicle/equipment inspections and equipment cleaning.	

If PPE was not used then list and describe the justifying circumstances:
Explain steps taken to correct any deficiencies identified:

Attachment 12-B

EMERGENCY SCENE COMPLIANCE MONITOR

DATE: **STATION:** **SCENE LOCATION:** **EMS RUN#:**
SUPERVISOR:

N/A	YES	NO	CRITERIA	OBSERVATIONS
			1. Personal protective equipment (masks, eye protection, gloves, & gown) was available.	
			2. Appropriate personal protective equipment was utilized based upon the possible degree of exposure.	
			3. Waterless cleanser was available at the point of use/area of possible contamination.	
			4. Gloves were donned immediately prior to patient contact.	
			5. Gloves were doffed immediately after patient contact.	
			6. Waterless cleanser was used appropriately following glove doffing.	
			8. Gloves were doffed prior to driving any emergency vehicle.	
			9. Hands were washed immediately upon patient transfer at the hospital AND immediately upon arrival back at quarters.	
			10. All needles and debris was removed from the scene.	
			11. Needle containers were used appropriately.	
			12. All contaminated waste was disposed appropriately.	
			13. All contaminated equipment was cleaned and dried at the hospital.	
			14. All potentially contaminated surface areas were cleaned at the hospital.	
			15. All waterless cleanser containers are at least ½ full.	
			16. All medical equipment used was clean and orderly prior to use.	

If PPE was not used then list and describe the justifying circumstances:

Explain steps taken to correct any deficiencies identified:

Bibliography

29 CFR 1910 Occupational Safety and Health Standards for General Industry, Section 1030 "Bloodborne Pathogens", as adopted by 13 NCAC 07F.0101 with amendments through April 1, 2003. Web link: http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051

United States Department of Labor, OSHA Instruction CPL-2-2.69 "Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens.
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OSHA Letter of interpretation 03/31/2003 - Acceptable use of antiseptic-hand cleansers for bloodborne pathogen decontamination and as an appropriate hand washing practice. Web link: http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=INTERPRETATIONS&p_id=24389

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